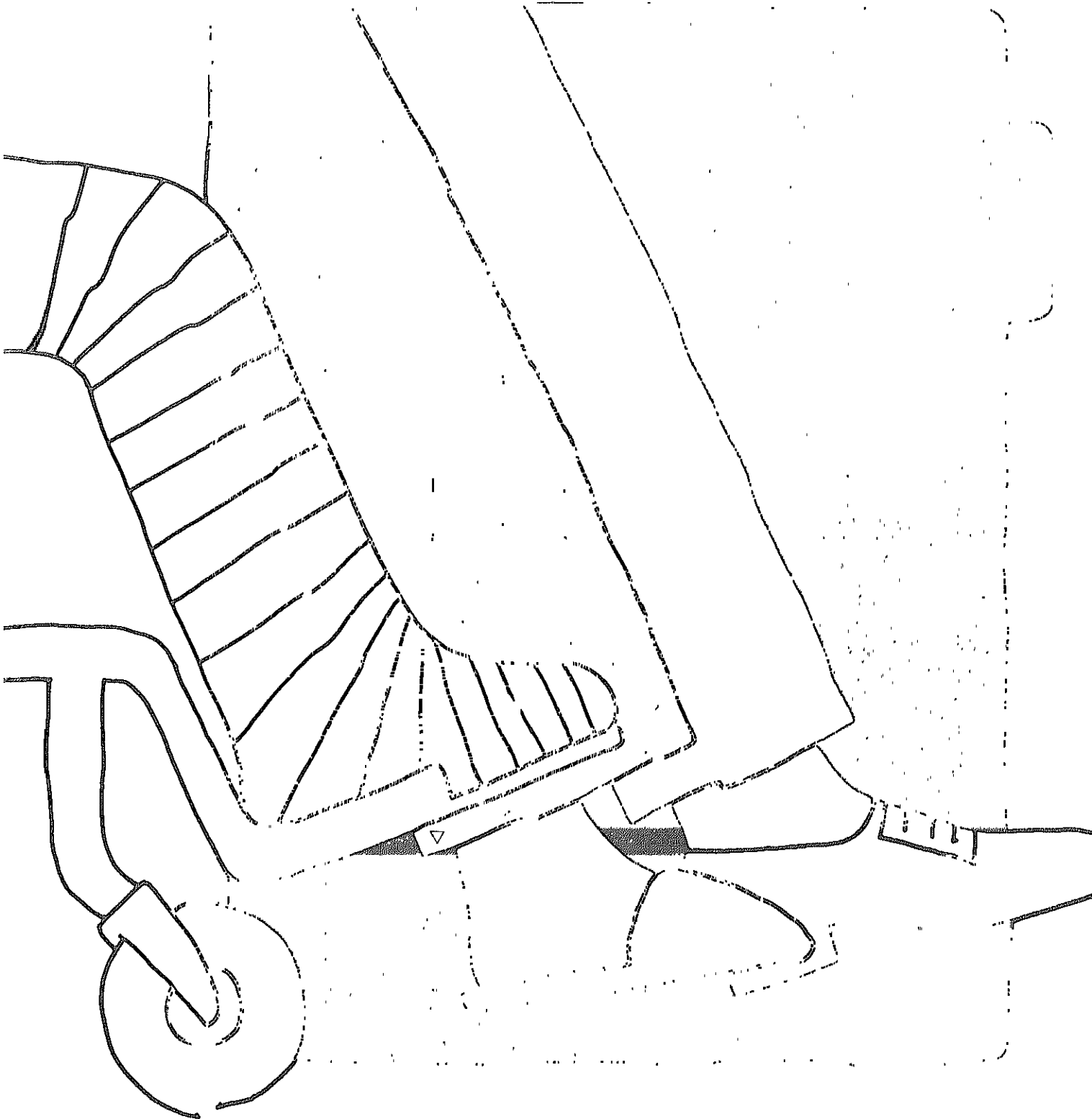




Advanced Course for Federal Agency Compensation Specialists

U S Department of Labor
Employment Standards Administration
Federal Employees' Compensation Program

392



Task Book



Advanced Course for Federal Agency Compensation Specialists

U.S. Department of Labor
Employment Standards Administration
Federal Employees' Compensation Program
1986

BEGIN WITH THIS BOOK

PREPARED BY:

JUDY BLAIR

BRENDAN BRANLEY

CELESTINE JOHNSON

PAT QUICK

SUSAN SHELTON

CYNTHIA TAYLOR

DEBRA YOUNGBLOOD

Task Book

How to Take This Course

WHERE AND WHEN TO TAKE THIS COURSE:

This course is advanced job training for federal agency compensation specialists.

The course will take approximately 12 hours to complete and is designed to be taken on the job. It should be taken in a quiet place that will be free from interruptions.

This course is divided into segments consisting of seven modules. You should take these in the order presented and it is recommended that you complete a module in one session of study.

The modules are:

- o Claims Review, starting on page 1 of this book
- o Controversion, starting on page 25 of this book
- o Third Party, starting on page 92 of this book
- o Light Duty, starting on page 115 of this book
- o Review of the Chargeback List, starting on page 172 of this book
- o Long Term Case Review, starting on page 193 of this book
- o Rehabilitation, starting on page 257 of this book

MATERIALS NEEDED:

- o Task Book
- o Resource Book

TAKING THE COURSE:

Sequences in the materials will be organized as follows:

- o This book contains the directions. It will refer you to the Resource Book and ask you to read some information or rules.
- o Next it will ask you to solve a problem or make a decision on the basis of the rules in the Resource Book. You will record your answers in this book (the Task Book).
- o Then you will compare your answers to the answer sheet in the Task Book.
- o If there are any major differences between your answers and the answer sheet, you will be instructed to re-read the section in the Resource Book.
- o After you have cleared up any differences in the answers, then you will begin a new sequence in the Task Book.

GO ON TO THE NEXT PAGE TO BEGIN THE COURSE.

Reading

A prerequisite to filling the role of the compensation specialist is to establish a claims processing system in your installation that will permit you to get the information you need quickly to do your job effectively. Your first reading will describe that system. The rest of the course will give you practice in reviewing claims and long term cases.

Now, turn to the Resource Book and read pages i through 7. When you have finished the reading, return to this book and go to page 1.

Module I Claims Review

In this module on Claims Review we will review some typical claims that have been submitted to the compensation office. You will be asked to make a number of decisions about the claims.

In reviewing these cases, you will begin the process of recognizing the INDICATOR, making your QUERY, EVALUATING the response and coming up with a RESOLUTION for the situation.

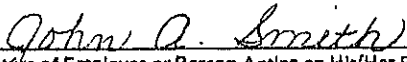
GO TO PAGE 2.

TASK BOOK
CLAIMS REVIEW
SMITH CASE
TASK 1

Read pages 8 - 10 and 14 - 16 in the Resource Book on examining the claim form and reviewing the medical report. When you have completed the reading, return to this page and follow the instructions below.

TASK:

Review the following CA-1 (Notice of Injury) and medical report for John A. Smith on pages 3 - 5. Look for any unresolved issues. Then turn to the worksheet on page 6 to answer the questions.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) <i>Smith, John A.</i>		2. Date of Birth <i>2-24-24</i>	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number <i>555-12-1212</i>	
5. Employee's Home Mailing Address (No., street, city, state, zip code) <i>P.O. Box 112 Scottsboro, Alabama 35807</i>			6. Home Telephone Area Code <i>205</i> Number: <i>555-2101</i>
7. Name and Address of Employing Agency <i>Tennessee Valley Authority Bellefonte Nuclear Plant Hollywood, Alabama 35803</i>		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) <i>Reactor Building</i>	
9. Date and Hour of Injury <i>9:00</i> (mo., day, year) <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM <i>Feb. 1, 1994</i>	10. Date of This Notice (mo., day, year) <i>Feb. 2, 1994</i>	11. Dependents Wife/Husband <input checked="" type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation <i>Electrician</i>
13. Cause of Injury (Describe how and why the injury occurred) <i>I picked up a drill (10 lbs.) to hand it to another Electrician and I got a catch in my back.</i>		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) <i>Strain low back</i>	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay. 			
16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).			
 Signature of Employee or Person Acting on His/Her Behalf			
17. Statement of Witness (Describe what you saw, heard or know about this injury) <i>Yesterday, John handed me a drill and then grabbed his back and said it was hurting</i>			
18. Witness' Signature <i>Ralph A. Longley</i>		19. Witness' Address <i>Box 75, Winding Lane Huntsville, Alabama 35805</i>	
		20. Date Signed (mo., day, year) <i>2/2/84</i>	

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency <u>Tennessee Valley Authority</u>		22. Bureau or Office <u>OEDC - Construction</u>	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <u>Lois P. Ulrickson, 124 Edney Bldg., Chattanooga, TN 37401</u>			
24. Regular Work Day Begins <u>7:30</u> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends <u>4:00</u> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <u>8</u>	26. Circle Days Paid Per Week S / M T W T F S
27. Date and Hour of Injury (mo., day, year) <u>9:00</u> <u>Feb. 1, 1984</u> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <u>Feb. 2, 1984</u>	29. Date and Hour Stopped Work (mo., day, year) <u>2:00</u> <u>Feb. 2, 1984</u> PM	30. If Pay Has Been Terminated, Give Date (mo., day, year) <u>N/A</u>
31. 45 Day Period Begins (mo., day, year) <u>Feb. 2, 1984</u>	32. Pay Rate When Employee Stopped Work <u>\$ 13.00 per hour</u>	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor at Time of Injury <u>James Walden</u>
35. Was Employee in Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for the Injury (mo., day, year) <u>Feb. 2, 1984</u>	39. Name and Address of Physician First Providing Medical Care <u>Dr. Paul Perkins</u> <u>1000 McCallie Avenue</u> <u>Chattanooga, TN 37401</u>		40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation for Basis of Controversion (See item 6 of Instruction Sheet), and, if applicable, the date pay was terminated. Attach Additional Sheets If More Space Is Needed.			
43. Filing Instructions <input type="checkbox"/> No Lost Time and No Medical Expense, Place this Form in Employee's Official Personnel Folder <input type="checkbox"/> Medical Expense Incurred or Expected, Forward this Form to OWCP <input checked="" type="checkbox"/> Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP			
44. All information requested on this Form has been furnished. If Not, it will be submitted by _____ (Fill in Date)			
45. Signature of Supervisor <u>James O. Walden</u>	46. Title and Office Phone Number <u>Cons. Supt.</u>		47. Date (mo., day, year) <u>2/8/84</u>

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION		ATTENDING PHYSICIAN'S REPORT	
1. NAME OF EMPLOYEE SMITH, JOHN A.		P.O. Box 112 Scratchers, Alabama 35801	
3. DATE AND HOUR OF INJURY (Mo., Day, Year) Feb 1, 1984		4. PERIOD OF DISABILITY CLAIMED AS A RESULT OF INJURY FROM 2-2-84 continuing	
5. WHAT IS YOUR STORY OF INJURY (Include details of injury, if any, and disease, if any, caused by the employment, DID EMPLOYEE SUFFER FROM?) Employee STATES HE STRAINED HIS BACK LIFTING DRILL WEIGHING APPROX 10 LBS AT WORK.			
6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.) X-RAYS REVEAL SEVERE DEGENERATIVE DISC DISEASE NO CHANGE SINCE 11/83 X-RAYS			
7. WHAT IS YOUR DIAGNOSIS? SAME AS #6			
8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DID INJURY REQUIRE HOSPITALIZATION? IF YES, DATE OF ADMISSION (Mo., Day, Year) DATE OF DISCHARGE		10. IS ADDITIONAL HOSPITALIZATION REQUIRED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. OPERATIONS (If any, describe type) CONTINUE TO RECOMMEND SPINAL FUSION		12. DATE OPERATIONS PERFORMED (Mo., Day, Year)	
13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? MEDICATIONS, MYELOGRAM		14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? UNKNOWN AT THIS POINT	
15. DATE OF FIRST EXAMINATION (Mo., Day, Year) 840202	16. DATES OF TREATMENT (Mo., Day, Year) 1982 and continuing		17. DATE OF DISCHARGE FROM TREATMENT (Mo., Day, Year) N/A
18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year) TOTAL DISABILITY FROM 2/2/84 TO CONTINUING PARTIAL DISABILITY FROM		19. DATE EMPLOYEE ABLE TO RESUME (Mo., Day, Year) N/A	
20. ADVISE IF EMPLOYEE IS ABLE TO RESUME WORK. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF YES FURNISH DATE ADVISED.			
21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS N/A			
22. GENERAL REMARKS AND RECOMMENDATIONS FOR EMPLOYEE'S CARE (If any) CONFIRMS MY RECOMMENDATION OF NEED FOR SPINAL FUSION. PATIENT REMAINS IN HOSPITAL			
23. SIGNATURE OF PHYSICIAN Paul Franklin MD		24. ADDRESS (Number, Street, P.O. Box, City, State, Zip Code) 1000 MCCALLIE AVENUE CHATTANOOGA, TN	
		25. DATE OF REPORT (Mo., Day, Year) 2/2/84	

CA-20
(REV. AUG. 1974)

TASK BOOK
CLAIMS REVIEW
SMITH CASE
TASK 1

Which of the following descriptions most closely describes the major issue in the case? Pick your answer and turn to the page and box indicated.

- a. Description of the injury submitted by the claimant is too incomplete. Turn to page 22, Box 2.
- b. There are no work limitations specified. Turn to page 23, Box 1.
- c. There is a lack of evidence of job-relatedness. Turn to page 33, Box 4.
- d. The type of injury claimed on the CA-1 is probably an occupational disease. Turn to Page 30, Box 1.

TASK BOOK
CLAIMS REVIEW
SMITH CASE
TASK 2

Should you wish to refer to the Resource Book, consult pages 14 and 15.

Which of the questions for the doctor listed below would provide the information most necessary for resolving the question of causality?

Select your answer and turn to the page indicated.

- a. Are the findings of severe degenerative disc disease causally related to the work injury reported? Turn to page 23, Box 4.
- b. When will the claimant be able to return to limited duty? Turn to page 33, Box 1.
- c. Is the total disability a result of the work injury reported? Turn to page 22, Box 1.
- d. To what extent did the injury claimed contribute to the claimant's current disability? Turn to page 30, Box 3.

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

Review the following CA-1 and medical disability certificates submitted by George R. Thomas and answer the questions on page 13.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) George R Thomas		2. Date of Birth 3-12-29	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
4. Social Security Number 006-15-1182		5. Employee's Home Mailing Address (No., street, city, state, zip code) 1106 Main St Towson, Maryland 21204	
6. Home Telephone Area Code: 301 Number: 667-4502		7. Name and Address of Employing Agency U.S. PS 900 E Fayette St Baltimore, MD 21233-9408	
8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) 2nd work floor - H.P.D. Operation 030		9. Date and Hour of Injury (mo., day, year) <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM 6/25/83 5:30	
10. Date of This Notice (mo., day, year) 7/15/83		11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input checked="" type="checkbox"/>	
12. Employee's Occupation Mail handler		13. Cause of Injury (Describe how and why the injury occurred) Unloading a belt from a truck, I fractured my left little toe when the belt slipped and ran over my foot	
14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) fractured left little toe		15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay. I did not think injury was serious.	
16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <div style="margin-top: 10px;"> <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). </div> <div style="text-align: center; margin-top: 20px;"> <u>George R. Thomas</u> Signature of Employee or Person Acting on His/Her Behalf </div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury) <div style="text-align: center; height: 100px; vertical-align: middle; font-size: 2em;"> N/A </div>			
18. Witness' Signature		19. Witness' Address	
20. Date Signed (mo., day, year)			

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency <i>USPS</i>		22. Bureau or Office <i>Balt MD 21233 #55466</i>	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>706 E Fayette St - Rm 217 - 722-4977 Balt MD 21233</i>			
24. Regular Work Day Begins <i>3:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM Ends <i>12:00</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week (S) M T (W) (T) (F) (S)
27. Date and Hour of Injury (mo., day, year) <i>6/25/83 5:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>7/9/83</i>	29. Date and Hour Stopped Work (mo., day, year) <i>7/7/83 12:00 PM</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year) <i>N/A</i>
31. 45 Day Period Begins (mo., day, year) <i>7/8/83</i>	32. Pay Rate When Employee Stopped Work <i>\$22.060 per hr</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM <i>7/15/83 3:30</i>	34. Name of Supervisor at Time of Injury <i>R Most</i>
35. Was Employee in Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for the Injury (mo., day, year) <i>7/9/83</i>	39. Name and Address of Physician First Providing Medical Care <i>Johns Hopkins Hospital 600 S Broadway Balt MD 21205</i>		40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If No, Furnish A Detailed Explanation. <i>Mr. Thomas was not assigned to unload bolts on 6/25/83</i>			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation for Basis of Controversy (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated. Attach Additional Sheets if More Space Is Needed.			
43. Filing Instructions <input type="checkbox"/> No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder <input checked="" type="checkbox"/> Medical Expense Incurred or Expected. Forward this Form to OWCP <input checked="" type="checkbox"/> Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP			
44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ (Fill in Date)			
45. Signature of Supervisor <i>R. Most</i>	46. Title and Office Phone Number <i>Supv. Harris</i>		47. Date (mo., day, year) <i>7/16/83</i>

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

DISABILITY CERTIFICATE:

JOHNS HOPKINS HOSPITAL
600 S. Broadway
Baltimore, MD 21205

7/8/83

George R. Thomas was seen in our Emergency Room on 7/8/83 and is unable to work through 7/9/83 due to a fracture of his left little toe. Patient states the injury happened at work on 6/25/83.

E. L. Wright, M. D.

Patient Instructions:

Tape toes for comfort. Take aspirin as needed.
Elevate the foot for 24 hours.

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

DISABILITY CERTIFICATE:

JOHNS HOPKINS HOSPITAL
600 S. Broadway
Baltimore, MD 21205

7/10/83

George R. Thomas was seen in our Emergency Room
on 7/10/83 and is unable to work through 7/14/83
as a result of a fractured left toe. Patient
states the injury occurred at work on 6/25/83.

R. A. Johnson, M. D.

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

Is George Thomas's claim ready to be sent to OWCP?

a. Yes ____ Turn to page 30, Box 2

b. No ____ Turn to page 22, Box 3

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 2

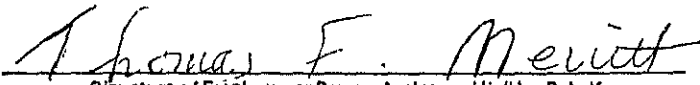
Pick the one statement below which represents a major issue or issues that need to be resolved in George Thomas's case before it can be sent to OWCP. Then turn to the page indicated next to your choice.

- a. There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place. Turn to page 22, Box 4.
- b. There is inadequate medical evidence to justify total temporary disability resulting from the injury claimed. Turn to page 33, Box 3.
- c. The Doctor's report raises questions about whether the injury occurred at work. Turn to page 31, Box 2.
- d. There were no witnesses to the injury. Turn to page 30, Box 4.
- e. Both a and b above. Turn to page 23, Box 2.
- f. Both a and c. Turn to page 24, Box 3.

TASK BOOK
CLAIMS REVIEW
MERRITT CASE
TASK 1

Read pages 11 - 13 in the Resource Book. Then review the following CA-1 and medical report on pages 16 - 18 for the claim of Thomas F. Merritt.

Look for any indicators of problems in the case. Then answer the questions on page 19.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Merritt, Thomas F.		2. Date of Birth 9/29/48	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number 100-56-6726	
5. Employee's Home Mailing Address (No., street, city, state, zip code) 405 Columbia ST Portsmouth, Va		6. Home Telephone Area Code: 804 Number: 393-8181	
7. Name and Address of Employing Agency Norfolk Naval Shipyard Industrial Relations Office Portsmouth, Va		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) Bldg 171	
9. Date and Hour of Injury 10:30 (mo., day, year) <input checked="" type="checkbox"/> AM 11/22/83 <input type="checkbox"/> PM	10. Date of This Notice (mo., day, year) 11/23/83	11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation LABORER
13. Cause of Injury (Describe how and why the injury occurred) I was moving office furniture when I lifted a chair and Felt a sharp pain in my wrist.		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) Right Wrist	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;">  Signature of Employee or Person Acting on His/Her Behalf </div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)	

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency <i>Naval</i>		22. Bureau or Office <i>Norfolk Naval Shipyard</i>	
23. Name and Address of Reporting Office (No. street, city, state, Zip Code) <i>Norfolk Naval Shipyard Industrial Relations Office, Portsmouth, Va. 23709</i>			
24. Regular Work Day Begins <i>7:20</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends <i>4:00</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week S <input type="checkbox"/> M <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> F <input type="checkbox"/> S
27. Date and Hour of Injury (mo., day, year) <i>11/22/83</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>11/23/83</i>	29. Date and Hour Stopped Work (mo., day, year) <i>N/A</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year)
31. 45 Day Period Begins (mo., day, year) <i>No time lost yet</i>	32. Pay Rate When Employee Stopped Work \$ _____ per _____	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM <i>N/A</i>	34. Name of Supervisor At Time of Injury <i>Mr. Wilson</i>
35. Was Employee In Performance of Duty At The Time of Injury? <input type="checkbox"/> Yes, <input checked="" type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report. <i>job orders do not show employee's work assignment as moving furniture on 11/22/83.</i>			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>11/22/83</i>	39. Name and Address of Physician First Providing Medical Care <i>Shipyard Dispensary Dr. Gerald McAdam 1011 London Blvd. Norfolk, Va</i>		40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If No, Furnish A Detailed Explanation. <i>employee's work assignment was not moving furniture.</i>			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor <i>Walter Wilson</i>	44. Title and Office Phone Number <i>Foreman 535-8162</i>		45. Date (mo., day, year) <i>11/23/83</i>

SHIPYARD DISPENSARY

Medical Entry

11/22/83 Patient complaining of pain in right leg on movement. Patient stated he slipped on wet surface and has since had pain in right leg.

Examination revealed full range of motion of right leg with a straight leg raising of 60°. X-rays were negative for fracture.

Treatment: Medication for pain and work restrictions for light duty assignment. Return to clinic in two weeks for re-evaluation.

S/ W A Moark
W. A. Moark, M. D.

12/5/83 Patient in for re-evaluation for right leg. Examination reveals full range of motion and no edema. Will return patient to full duty. However, he requests to be referred to his private medical doctor. Will grant this request and patient was instructed to contact compensation office.

S/ W A Moark
W. A. Moark, M. D.

Enclosure 2

TASK BOOK
CLAIMS REVIEW
MERRITT CASE
TASK 1

From the problems listed below, identify the one answer that applies in this case. Select your answer below and turn to the page indicated to check your answer.

- a. Both b and c are problems. Turn to page 24, Box 2.
- b. There is a conflict between the supervisor's statement of work assignment and the claimant's description of injury. Turn to page 33, Box 2.
- c. There is a conflict between the Ship Dispensary medical report and the claimant's description of the part of the body injured. Turn to page 31, Box 1.
- d. There are no witnesses to the injury claimed. Turn to page 41, Box 2.

TASK BOOK
CLAIMS REVIEW
MERRITT CASE
TASK 2

To resolve the conflict between the supervisor's statement of work assignment and the claimant's description of injury, which of the following sources is most important?

- a. Interview the claimant. Turn to page 24, Box 1
- b. Interview the supervisor. Turn to page 23, Box 3
- c. Look for witnesses. Turn to page 170, Box 2
- d. Get a more detailed medical report from the Dispensary.
Turn to page 34, Box 4

**TASK BOOK
CLAIMS REVIEW
MERRITT CASE
TASK 3**

To resolve the conflict between the Ship Dispensary medical report and the claimant's description of the part of the body injured which of the following would you do? After you select your answer, turn to the page indicated.

- a. Interview the claimant. Turn to page 41, Box 3
- b. Interview the supervisor. Turn to page 24, Box 4
- c. Look for witnesses. Turn to page 34, Box 1
- d. Get a more detailed medical report from the dispensary.
Turn to page 31, Box 3

1

Question "c" does not ask for a description of how much the work injury contributed to the disability.

Return to page 11 and try again.

2

Choice "a" is not the major issue. Since the degenerative disc disease is an ample explanation for his total disability, we do not need a better description of the accident to explain how it could result in such a severe condition.

Return to page 6 and make another selection.

3

Correct. The case is not ready to be submitted to OWCP.

Turn to page 14 for the next task.

4

True. There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place. However, there is one other issue that should be resolved at this time.

Return to page 14 and try again.

1

Choice b. is not really an issue at this point. The fact that the work limitations are not specified is not an issue since the claimant is hospitalized. It would only become an issue after establishing a causal relationship between picking up the drill and the claimant's disability.

Return to page 6, review the case and select another answer.

From page 14

2

Correct. Both of these are issues.

(a.) There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place.

and

(b.) There is inadequate medical evidence to justify total temporary disability resulting from the injury claimed.

Turn to page 15 for the next task.

From page 20

3

This is not really necessary. The supervisor is already on record as stating that the employee was not assigned to move furniture, even though he has not come forth with other evidence.

Return to page 20 and make another choice.

From page 7

4

Question a. "are the findings of severe degenerative disc disease causally related to the work injury reported?" is not the best question. We already know that severe degenerative disc disease preceded the work injury and therefore is not a result of it.

Return to page 7 and try again.

1

Correct. It is important to give the claimant the opportunity to explain why he was moving furniture when that was not his assignment. Find out if he was working with anyone. Were there any witnesses?

Now turn to page 21 for the next task.

2

Correct. Both b and c are problems.

Turn to page 20 for the next task.

3

You are partly right. There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place. However item c "The Doctor's report raises questions about whether the injury occurred at work" is not a major issue. It is true that the report does not provide a complete history of injury. This is just one of the weaknesses of the medical evidence. Return to page 14 and make another selection.

4

No. The supervisor has no direct information on how the injury happened or what part of the body was affected. Return to page 21 and make another choice.

As in the previous module, you will be given a case and a series of tasks. For each case you will be asked to:

- a. Decide whether the case may be controverted on the basis of the information given,
- b. Decide what additional information you need, if any,
- c. Evaluate any additional information, and decide whether the claim should be controverted.

In making a decision on a given case, you will need to be able to recognize any indicators of a problem. Read the Resource pages 17 - 20 on Case Review Process.

TURN TO PAGE 26 TO BEGIN THE FIRST CASE.

SMITHERS CASE
TASK 1

Before beginning this case, read the Resource Book on Controversion, pages 26 and 27 up to Number 2.

Review the attached CA-1 completed by John E. Smithers and received for processing in the compensation office on April 2, 1984. Then turn to page 29 to do the task.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Smithers John E		2. Date of Birth 11-01-50	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number 123-58-3070	
5. Employee's Home Mailing Address (No., street, city, state, zip code) 702 East Fayette Street Baltimore, Maryland 21233		6. Home Telephone Area Code: 301 Number: 436-8051	
7. Name and Address of Employing Agency U.S. Postal Service 900 West Pratt Street Baltimore, Maryland 21202-9208		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) 1208 Walker Avenue	
9. Date and Hour of Injury (mo., day, year) <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM 2/20/84 12:30	10. Date of This Notice (mo., day, year) 2/20/84	11. Dependents Wife/Husband <input checked="" type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation Letter Carrier
13. Cause of Injury (Describe how and why the injury occurred) While delivering a package, dog ran out opened door and bit my leg		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) right leg	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay. I gave it to my supervisor and he lost it.			
16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;"><u>John E. Smithers</u> Signature of Employee or Person Acting on His/Her Behalf</div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury) None			
18. Witness' Signature		19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Sept. 1978

21. Department or Agency US Postal Service		22. Bureau or Office Baltimore, Md 21202-9208	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) 900 West Pratt Street Baltimore, MD 21202-9208			
24. Regular Work Day Begins 6 00 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends 2 30 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day 8	
26. Circle Days Paid Per Week S <input type="checkbox"/> <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> T <input type="checkbox"/> F <input checked="" type="checkbox"/> S			
27. Date and Hour of Injury (mo., day, year) 2/20/84 12 30 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		28. Date Reporting Office Received Notice of Injury (mo., day, year) 2/20/84 (Verbal)	
29. Date and Hour Stopped Work (mo., day, year) 2/20/84 12 30		30. If Pay Has Been Terminated, Give Date (mo., day, year) N/A	
31. 45 Day Period Begins (mo., day, year) 2/21/84		32. Pay Rate When Employee Stopped Work \$22.402 per yr	
33. Date and Hour Employee Returned to Work (mo., day, year) 2/22/84 6 00 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		34. Name of Supervisor at Time of Injury Ray Jones	
35. Was Employee in Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible. Homeowner 1208 Walker Avenue Baltimore, MD 21202			
38. Date Employee First Obtained Medical Care for the Injury (mo., day, year) 2/20/84		39. Name and Address of Physician First Providing Medical Care Johns Hopkins Hospital 600 Broadway Baltimore, MD. 21205	
40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Give Full Explanation for Basis of Controversy (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated. Attach Additional Sheets If More Space Is Needed.			
43. Filing Instructions <input type="checkbox"/> No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder <input checked="" type="checkbox"/> Medical Expense Incurred or Expected. Forward this Form to OWCP <input checked="" type="checkbox"/> Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP			
44. All information requested on this Form has been furnished. If Not, it will be submitted by _____ (Fill in Date)			
45. Signature of Supervisor Ray Jones		46. Title and Office Phone Number Supv 922-4908 Delivery	
47. Date (mo., day, year) 4/2/84			

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 1

Select the letter next to the statement below that best describes the issue involved and turn to the page indicated to check your answer.

- a. There is no issue. The claim is ready to be submitted to OWCP. Turn to page 41 Box 1.
- b. The issue is that this claim should be an occupational disease claim. Turn to page 31 Box 4.
- c. The issue is that the injury was not reported on an approved form within 30 days after the injury. Turn to page 34 Box 3.
- d. The issue is that the injury occurred off the employing agency's premises and the employee was not in performance of duty. Turn to page 42 Box 2.

1

Choice "d" - that the injury claimed is an occupational disease is possible. But, there is no evidence that the degenerative disc disease is work-related, nor is the claimant asserting this.

Return to page 6 and make another choice.

From page 13

2

You said yes. You are not quite correct. There are at least two "issues" that should be resolved first. First, review page 9 and pages 14 and 15 of the Resource Book. Then return to page 13 and answer the question again.

From page 7

3

Correct. Question d. "To what extent did the reported injury contribute to the claimant's current disability?" is the best answer. The disability may be entirely due to the pre-existing condition and hence not compensable. However, any part of the current disability which has resulted from the reported injury is compensable.

Go to page 8 to do another case.

From page 14

4

Choice d "There were no witnesses to the injury" is not a good choice. The claimant states that there were no witnesses to the injury. There, in fact, does not have to be a witness to make a claim valid. Return to page 14 and select another answer.

1

This is correct. There is a conflict between the ship dispensary medical report and the claimant's description of the part of the body injured.

Now return to page 19 and review the choices. Are you sure there are no others?

2

Item c "The Doctor's report raises questions about whether the injury occurred at work" is not a major issue. It is true that the report does not provide a complete history of injury. This is just one of the weaknesses of the medical evidence. Answer "b" gets more to the point of the larger issue of lack of medical evidence.

Return to page 14 for another try.

3

The dispensary as a source would not be helpful at this point. We first need a clearer description of how the injury occurred and how the different parts of the body were affected.

Return to page 21 for another attempt.

4

No. The dog bite on the leg is a traumatic injury, not an occupational disease.

Return to page 29 and select another answer.

CONTROVERSION
SMITHERS CASE
TASK 2

At this point, which step must you take? Select one of the choices below, then turn to the page indicated to check your answer.

- a. Contact the claimant's supervisor to see if there were any witnesses who saw the claimant give the form to the supervisor. Turn to page 34, Box 2.
- b. Contact the claimant's supervisor to verify the date the claim form was first submitted by the claimant to the supervisor. Turn to page 41, Box 4.
- c. Contact the claimant to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. Turn to page 43, Box 2.
- d. Both a and c above. Turn to page 44, Box 1.
- e. Both b and c above. Turn to page 42, Box 3.

1

The question asked in b. "when will the claimant be able to return to limited duty?" may turn out to be important, but the more basic issue is still establishment of causality.

Return to page 7 and select another answer.

2

This is correct. There is a conflict between supervisor's statement of work assignment and claimant's description of injury.

Return to page 19. Are you sure there are no other problems?

3

Very good. There is inadequate medical evidence to justify total temporary disability resulting from the injury claimed. However, there is another issue that should be resolved now.

Return to page 14 to make another selection.

4

The correct answer is "c" - lack of evidence of job relatedness. The major issue is the cause of the condition of the person's back. The doctor's medical report clearly states that the claimant had severe degenerative disc disease several months prior to the injury reported. It also states that the current condition is the same as it was then.

Turn to page 7 to begin the next task.

1

This is not the best choice. There may be witnesses who could supply useful information, but there is a far more direct route. Return to page 21 for another selection.

From page 32

2

Contacting "the claimant's supervisor to see if there were any witnesses who saw the claimant give the form to the supervisor" is not a necessary step. If the supervisor does not remember that the claimant gave him the form, he certainly will not remember any witnesses.

Return to page 32 and make another choice.

From page 29

3

Correct. The best answer is "3" - that the injury was not reported on an approved form within 30 days after the injury. The date of injury was 2/20/84, but the claim was not received in the compensation office until April 2, 1984, after the 30 day filing limit.

Turn to page 32 to continue.

From page 20

4

No. Medical information, even if complete, would not settle the problem of where the claimant was when he sustained his injury.

Return to page 20 and try again.

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 3

Read pages 32 - 34 in the Resource Book in the section on Controversion. You might also want to review pages 26 - 27 in the Resource.

The claimant's supervisor has advised you that he has no record of the employee ever completing Form CA-1 until April 2, 1984. He has given you the written statement on the following page. You have also requested and obtained a written statement from the claimant.

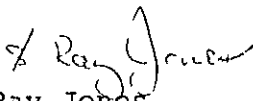
Read these two statements on the two following pages and answer the questions on pages 38 - 40.

STATEMENT

April 3, 1984

TO: Mary Denton
Injury Compensation Specialist

This is in response to your telephone call requesting information on a claim submitted by John E. Smithers. Mr. Smithers requested a CA-1 form from me yesterday and gave it back to me to sign on the same day April 2, 1984. This is the only time this employee requested a claim form for the dog bite he told me he received back in February.


Ray Jones
Supervisor, Delivery

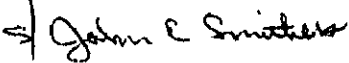
TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 3

STATEMENT

April 3, 1984

TO: Mary Denton
Injury Compensation Specialist

I submitted a CA-1 to my supervisor on 2/20 when I left at 12:30 p.m. The supervisor did not give me a receipt for the CA-1. I did not know I was supposed to get one.


John E. Smithers

You have decided to controvert the claim.

Select the statement below that best describes your basis for controverting this claim. After choosing your answer, turn to the page indicated to check your answer.

- a. The injury was not reported on an approved form within 30 days of the injury. Turn to page 44, Box 4.
- b. The injury occurred off the employing agency's premises and the employee was not involved in official "off premises" duties. Turn to page 42, Box 1.
- c. The injury was caused by the employee's willful misconduct. Turn to page 50, Box 3.
- d. Causal relationship has not been established. Turn to page 43, Box 3.

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 4

Indicate whether or not you would terminate COP and your rationale for that decision by selecting the best answer from the choices below. Then turn to the page indicated.

- a. You would not terminate COP because the employee went to the hospital and there are probably medical bills that have to be paid. Turn to page 43, Box 1.
- b. You would terminate COP because the injury did not occur during the performance of duty. Turn to page 44, Box 3.
- c. You would terminate COP because a claim not being timely filed is one of the reasons you can legally terminate COP. Turn to page 50, Box 1.
- d. You will terminate COP because there is no medical evidence that the injury ever occurred. Turn to page 42, Box 4.

CONTROVERSION
SMITHERS CASE
TASK 5

Circle the letter of the item below you would not enclose as documentation in your controversion package to OWCP for this case. Then turn to the page given at the end of your selection to check your answer.

- a. The claimant's written statement. Turn to page 43, Box 4.
- b. The supervisor's written statement. Turn to page 50, Box 2.
- c. The CA-1 form. Turn to page 44, Box 2.
- d. A medical report. Turn to page 63, Box 4.

1

Not correct. There is a basic issue in this case. Return to page 29 for another try.

2

Not really. Although there may be witnesses, the best source of finding them would be through the claimant.

Return to page 19 and make another selection.

3

Correct. For the conflict in medical information, again the employee would be the best source. The conflict between the employee's statement and the dispensary report is obvious. If the claimant is asked to describe in detail exactly how the injury occurred, he may have a rationale that connects the wrist and leg injuries. Further, we do not know at this point whether he has used, or is using other medical facilities, such as a private physician, to treat the injured wrist. Turn to page 25 to begin the next module.

4

Correct. It is important to contact the claimant's supervisor (choice "b") to verify the date the claim form was first submitted by the claimant to the supervisor. If the supervisor remembers the claimant giving the CA-1 to him within the 30 day time period and the supervisor did, in fact, lose it, then the claimant has fulfilled his responsibility. But there is also one other step you must take.

Return to page 32 and select the other necessary step.

1

This is not true. The employee was involved in official duties, even though off premises.

Return to page 38 to make another selection.

From page 29

2

It is true that the injury occurred off the agency's premises, but since it was in the performance of duty (delivering mail) it is clearly covered.

Return to page 29 and select another answer.

From page 32

3

Correct. Both b and c are necessary. It is important to contact the claimant's supervisor ("b") to verify the date the claim form was first submitted to the supervisor. If the supervisor remembers the claimant gave the CA-1 to him within the 30 day time period and the supervisor did, in fact, lose it, then the claimant has fulfilled his responsibility. But there is also another step you must take. You must contact the claimant ("c") to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. If he can produce it, this will substantiate his claim and he will have fulfilled his responsibility, even if the supervisor subsequently lost the original form. Now go to page 35.

From page 39

4

You have not reached the point of considering medical evidence yet, so choice "d." - "no medical evidence that the injury ever occurred" is not correct.

Return to page 39 and make another selection.

1

No. This provides no legal basis for controverting COP.
Return to page 39 and make another choice.

2

You want to contact the claimant (choice "c") to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. If he can produce the receipt this will substantiate his claim and he will have fulfilled his responsibility, even if the supervisor subsequently lost the original form. However, there is one other thing you should do.

Return to page 32, examine the case and select another alternative.

3

No. Establishment of causal relationship is not an issue in this case.

Return to page 38 for another selection.

4

No. In this case the claimant's written statement is a necessary part of the claim, since it is the claimant's explanation of the lack of timeliness.

Return to page 40 and select another answer.

1

Choice "c" is correct. You want to contact the claimant to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. If he can produce the receipt he will have fulfilled his responsibility, even if the supervisor subsequently lost the original form. There is one other thing you should do. However, choice a, contacting the claimant's supervisor is not a necessary step. If the supervisor does not remember that the claimant gave him the form, he certainly will not remember any witnesses. Return to page 32 and make another selection.

From page 40

2

No. The CA-1 form is always required. It is the official claim form.

Return to page 40 and make another selection.

From page 39

3

Not so. The injury did occur during the performance of duty - delivering mail.

Return to page 39 and try again.

From page 38

4

Correct. The basis for controverting this claim is the injury was not reported on an approved form within 30 days of the injury.

Now turn to page 39 for the next task.

MURPHY CASE

First, read pages 21 - 25 in the Resource Book.

Then review the CA-1 and medical report which follow on pages 46 - 48 to determine if this case should be controverted and answer the questions on page 49.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) <i>Murphy, Samuel</i>		2. Date of Birth <i>1-10-50</i>	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
4. Social Security Number <i>350-46-1130</i>		5. Employee's Home Mailing Address (No., street, city, state, zip code) <i>8500 So. Halsted, apt 3C</i>	
6. Home Telephone Area Code: <i>312</i> Number: <i>881-7110</i>		7. Name and Address of Employing Agency <i>Chicago Buck Mail</i> <i>2500 W. Roosevelt Rd</i> <i>Chicago, Ill 60609</i>	
8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) <i>1st floor hallway</i>		9. Date and Hour of Injury (mo., day, year) <i>1-25-84</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	
10. Date of This Notice (mo., day, year) <i>1-25-84</i>		11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	
12. Employee's Occupation <i>RmH</i>		13. Cause of Injury (Describe how and why the injury occurred) <i>Ernest Jones hit me in the mouth with his fist</i>	
14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) <i>Split my lip and knocked 2 teeth loose</i>		15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.	
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work.			
<input type="checkbox"/> a. Sick and/or annual leave			
<input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).			
<i>Samuel Murphy</i> Signature of Employee or Person Acting on His/Her Behalf			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature		19. Witness' Address	
20. Date Signed (mo., day, year)			

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency <i>U.S. Postal Service</i>		22. Bureau or Office	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>Chicago Bull Mail Co 7500 W. Roosevelt Rd Ch. Ill 60609</i>			
24. Regular Work Day Begins <i>7:00</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends <i>3:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week S M <u>T</u> <u>W</u> <u>T</u> <u>F</u> <u>S</u>
27. Date and Hour of Injury (mo., day, year) <i>1-25-84</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>1-25-84</i>	29. Date and Hour Stopped Work (mo., day, year) <i>N/A</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year)
31. 45 Day Period Begins (mo., day, year) <i>N/A</i>	32. Pay Rate When Employee Stopped Work \$ <i>9.79</i> per <i>hr</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	34. Name of Supervisor At Time of Injury <i>Eileen Taylor</i>
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Furnish Detailed Report. <i>Clmt and employee Jones got into a fist fight when a hand truck</i>			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>1/25/84</i>	39. Name and Address of Physician First Providing Medical Care <i>Mayfield Hospital</i>		40. Do Medical Reports Show Employee Is Disabled For Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversy (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor <i>Eileen Taylor</i>	44. Title and Office Phone Number <i>Supv. of Mails</i>		45. Date (mo., day, year) <i>1/26/84</i>

LOYOLA HOSPITAL
Emergency Room Report

This 34 year old male was treated for laceration of the mouth on 1/25/84. X-rays of the teeth revealed a loosening and displacement of the 2 top incisors on the left. Patient was seen by the orthodontist, who administered sodium and salt solution for rinse over gums. Patient is to continue using sodium and salt water until loosening of the incisors resolves.

TURN TO THE NEXT PAGE.

TASK BOOK
CONTROVERSION
MURPHY CASE

Which of the following statements describes the appropriate course of action. After selecting your answer, turn to the page indicated next to the answer.

- a. Do not controvert the case because the fight was due to a matter relating to work. Turn to page 79, Box 1.
- b. Interview both parties involved in the fight to clearly establish that the fight was really over a work matter. Turn to page 63, Box 3.
- c. Do not controvert the case since there was no time loss. Turn to page 50, Box 4.
- d. Controvert the case because the medical report does not establish the job relatedness of the injury. Turn to page 80, Box 2.

1

You are correct. You would terminate COP because a claim filed later than 30 days after injury is not timely filed and is one of the reasons you can legally terminate COP.

Turn to page 40 for the next task.

2

No. The supervisor's written statement is an essential part of the evidence for controversion.

Return to page 40 and try again.

3

This is not true. There is no evidence that the injury was caused by the employee's willful misconduct.

Return to page 38 and select a different answer.

4

No. The fact that there is no time loss is not relevant. There are medical costs involved.

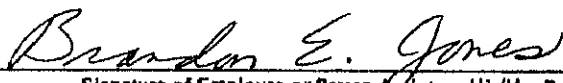
Return to page 49 and make another selection.

TASK BOOK
CONTROVERSION
JONES CASE

First read pages 27 (paragraph 2.) - 31 in the Resource Book.

Then review the case material for Brandon E. Jones on
pages 52 - 56.

Then turn to page 57 to answer the questions.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Jones, Brandon E.		2. Date of Birth 6/15/46	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number 318-42-0892	
5. Employee's Home Mailing Address (No., street, city, state, zip code) 313 Bayberry Lane Chesapeake, Virginia 23709		6. Home Telephone Area Code: 804 Number: 488-1240	
7. Name and Address of Employing Agency Norfolk Naval Shipyard Industrial Relations Office Portsmouth, Va 23709		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) USS JFK	
9. Date and Hour of Injury (mo., day, year) <input checked="" type="checkbox"/> AM 7/8/83 7:30 PM	10. Date of This Notice (mo., day, year) 7/8/83	11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation Pipefitter
13. Cause of Injury (Describe how and why the injury occurred) I was laying 18" piping when I bent down to get my wrench and hit my elbow on the pipe.		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) Right Elbow	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;">  Signature of Employee or Person Acting on His/Her Behalf </div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature		19. Witness' Address	
		20. Date Signed (mo., day, year)	

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY			
21. Department or Agency NAVY		22. Bureau or Office Norfolk Naval Shipyard	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) Norfolk Naval Shipyard, Industrial Relations Office, Portsmouth, VA 23709			
24. Regular Work Day Begins 7:20 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends 4:00 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day 8	26. Circle Days Paid Per Week S (M) (T) (W) (T) (F) S
27. Date and Hour of Injury (mo., day, year) 7/8/83 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) 7/8/83	29. Date and Hour Stopped Work (mo., day, year) 7/9/83	30. If Pay Has Been Terminated, Give Date (mo., day, year)
31. 45 Day Period Begins (mo., day, year) 7/9/83	32. Pay Rate When Employee Stopped Work \$ — per —	33. Date and Hour Employee Returned to Work (mo., day, year) Still Out <input type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor At Time of Injury Mr. Barnes
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) 7/9/83	39. Name and Address of Physician First Providing Medical Care Dr. William Harris 210 Washington Ave Norfolk, VA 23710		40. Do Medical Reports Show Employee Is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor C. Barnes	44. Title and Office Phone Number Foreman 346-4271		45. Date (mo., day, year) 7/8/83

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A - AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Dr William Harris
210 Washington Ave
Norfolk, Va 23710

2. EMPLOYEE'S NAME (Last, first, middle)

Jones, Brandon E.

3. DATE OF INJURY
(mo., day, year)

7/8/83

4. OCCUPATION

Pipefitter

5. DESCRIPTION OF INJURY OR DISEASE

was laying 18" p.pins when right elbow
struck the pipe

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

- ☒ A- FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.
- ☐ B- THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT, YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)

Susan M. Peters

9. TITLE

Head, Employee Services Div

10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER

(804) 396-7886

11. DATE (mo., day, year)

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address)

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.

Dept. or Agency

Navy

Bureau or Office

Norfolk Naval Shipyard

Local Address
(Including Zip Code)

Portsmouth, Va 23709

NAME (Print or type—Last, First, Middle Initial)

Jones, Brandon E.

IDENTIFICATION NO.

56-42876

ORGANIZATIONAL UNIT

Nashville Naval Shipyard

FROM (Mo., Day, Hr.)

7/5/83

a.m.

NO. OF HOURS

p.m.

TYPE

☒ ANNUAL—"I understand that any annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP." ☒ SICK—Complete other side of this form.

LEAVE

☐ WITHOUT PAY ☐ COMPENSATORY ☒ OTHER (Specify) COP + Comp

TO (Mo., Day, Hr.)

Continuing

a.m.

p.m.

REMARKS

Hurt on the job

SIGNATURE OF EMPLOYEE

Brandon E. Jones

DATE

7/9/83

INSTRUCTIONS: Complete above part of form. If applying for sick leave, check appropriate box on back (top) of form. If you were under care of a doctor, he should complete "CERTIFICATE OF PHYSICIAN OR PRACTITIONER" also on back

OFFICIAL ACTION ON APPLICATION

☐

APPROVED

☐

DISAPPROVED (If disapproved, give reason)

SIGNATURE AND DATE

STANDARD FORM 71
Revised November 1965

71-108

APPLICATION FOR LEAVE

U.S. CIVIL SERVICE COMMISSION
FPM Suppl. 570-2

EMPLOYEE (If applying for sick leave)	DURING THIS ABSENCE I WAS	INCAPACITATED FOR DUTY BY: <input type="checkbox"/> SICKNESS <input checked="" type="checkbox"/> ON-THE-JOB INJURY <input type="checkbox"/> OFF THE JOB INJURY <input type="checkbox"/> PREGNANCY AND CONFINEMENT	UNDERGOING MEDICAL, DENTAL, OR OPTICAL EXAMINATION OR TREATMENT <input type="checkbox"/>
	<input type="checkbox"/> REQUIRED TO CARE FOR A MEMBER OF MY FAMILY WITH A CONTAGIOUS DISEASE (Give name and relationship of member of family, and name of disease)		<input type="checkbox"/> REQUIRED TO BE ABSENT BECAUSE OF EXPOSURE TO CONTAGIOUS DISEASE (Give name of disease and circumstances of exposure)
CERTIFICATE OF PHYSICIAN OR PRACTITIONER	NAME OF EMPLOYEE		PERIOD UNDER PROFESSIONAL CARE
	Brandon E. Jones		FROM (Mo., Day, Year)
	POSITION OCCUPIED		7/8/83
	Pipe Fitter		TO (Mo., Day, Year)
REMARKS		Continuing	
RT Elbow - sprain			
THE EMPLOYEE NAMED WAS UNDER MY PROFESSIONAL CARE DURING THE PERIOD STATED ABOVE. From the medical standpoint, his condition during this period was such that I considered it inadvisable for him to report to work.			
SIGNATURE		DATE	
William Harris		7/9/83	

U S GOVERNMENT PRINTING OFFICE 1966 O-210-164

TASK BOOK
CONTROVERSION
JONES CASE

July 8, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.D. 20211


RE: Jones, Brandon E.

Dear Sir:

The above patient was first examined by me on 6/24/83. The patient's chief complaint was that of painful movement concerning the right arm particularly in the elbow area.

The patient was instructed on certain excercises, given a prescription for pain, and advised to return in 2 weeks.

Sincerely

A handwritten signature in dark ink, appearing to read "Wm. Harris M.D.", written in a cursive style.

William Harris, M. D.

TURN TO THE NEXT PAGE.

TASK BOOK
CONTROVERSION
JONES CASE

Select the most basic medical question that needs to be resolved. Then turn to the page after your answer.

- a. You need a medical report of the treatment of the 7/8 injury. The certificate of the physician does not have adequate information about this. Turn to page 80, Box 1.
- b. Did the 7/8 injury contribute to the current disability? Turn to page 63, Box 2.
- c. What work limitations, if any, have been imposed on the claimant? Turn to page 79, Box 4.

TASK BOOK
CONTROVERSION
JOHN CASE

You have already read the resource material needed to resolve this case. If you wish to refresh your memory, consult pages 21 - 31 in the Resource Book.

Review the following CA-1 and medical report on pages 59 - 61 to determine if this case should be controverted. Then turn to page 62 to do the task.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) <i>John. Irene R</i>		2. Date of Birth <i>2/11/40</i>	3. <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
		4. Social Security Number <i>56301-7240</i>	
5. Employee's Home Mailing Address (No., street, city, state, zip code) <i>3705 W. Madison</i>		6. Home Telephone Area Code: <i>NA</i> Number: <i>NA</i>	
7. Name and Address of Employing Agency <i>Chicago Public Mail Center 7501 W. Roosevelt Rd Chicago, Ill. 60630</i>		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) <i>Star Route #143</i>	
9. Date and Hour of Injury (mo., day, year) <i>10-4-83</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	10. Date of This Notice (mo., day, year) <i>10/10/83</i>	11. Dependents Wife/Husband <input checked="" type="checkbox"/> Children Under 18 Years Old <input checked="" type="checkbox"/>	12. Employee's Occupation <i>PMN</i>
13. Cause of Injury (Describe how and why the injury occurred) <i>Lifting mail sacks</i>		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) <i>hurt lower</i>	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay. <i>I was sent home for I wasn't able to complete the rest</i>			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;"><i>John R. John</i> Signature of Employee or Person Acting on His/Her Behalf</div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)	

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY			
21. Department or Agency <i>U.S. Postal Service</i>		22. Bureau or Office	
23. Name and Address of Reporting Office (No, street, city, state, Zip Code) <i>7500 W. Roosevelt Rd Forest Park IL 60130</i>			
24. Regular Work Day Begins <i>3:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM Ends <i>12:00</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week S <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> F S
27. Date and Hour of Injury (mo., day, year) <i>10/4/83</i> <input type="checkbox"/> AM <input type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>10/4/83</i>	29. Date and Hour Stopped Work (mo., day, year) <i>10/4/83</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year)
31. 45 Day Period Begins (mo., day, year)	32. Pay Rate When Employee Stopped Work <i>\$2065 per hr.</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor At Time of Injury <i>George Fortune</i>
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Furnish Detailed Report. <i>Clmt came back from lunch intoxicated</i>			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>10/4/83</i>	39. Name and Address of Physician Firm Providing Medical Care <i>Oak Park Hospital 318 W. Madison, Oak Park</i>		40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If No, Furnish A Detailed Explanation. <i>Clmt had alcohol on her breath and was slurping her words</i>			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversy (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor <i>George Fortune</i>	44. Title and Office Phone Number <i>Supv Mail</i>		45. Date (mo., day, year) <i>10/15/83</i>

OAK PARK HOSPITAL
Emergency Room Report

This 44 year old female was seen in the emergency room for acute low back pain. Patient states that she hurt her back lifting a mail sack. Patient lumbar spine X-rays were negative for fix. EKG revealed normal readings, eye, ear, nose and head exam was normal. Blood pressure was 100/90, chest was clear. Examination of the lumbar spine revealed acute muscle spasm upon rest. Patient's blood analysis revealed .189 level of alcohol concentration in the blood. Legal point of intoxication is 0.10.

Patient was given a prescription for muscle relaxants and pain medications, and advised to go home for bed rest 1 week and return for exam. Patient advised to refrain from taking medication until 8 hours have elapsed. Patient left emergency room accompanied by her husband.

Jose Hernandez, M.D.

GO ON TO NEXT PAGE.

TASK BOOK
CONTROVERSION
JOHN CASE

Circle the letter of the answer which represents the best course of action to now take. Then turn to the page listed next to the answer you select.

- a. The claim is to be controverted because the claimant was legally intoxicated and would not have been able to maintain her balance. Turn to page 80, Box 3.
- b. The compensation specialist should get additional clarification from the attending doctor on how intoxication may have contributed to her accident. Turn to page 79, Box 3.
- c. The claim cannot be controverted because the intoxication did not cause the injury. Turn to page 63, Box 1.

1

Correct. The best answer is c. This case is not controvertible even though claimant was acutely intoxicated since it did not cause the injury.

Turn to page 64 to begin a new case.

2

Correct. The most basic question is "did the 7/8 injury contribute to the current disability?" (If even a part of the current disability was caused by the work injury it is compensable.)

Turn to page 58 to begin the next case.

3

No. It is not necessary to interview both parties in this case because the supervisor's description clearly indicated it was a work related incident.

Return to page 49 and make another selection.

4

Correct. A medical report would not provide any information on the basis on which you are controverting this case, namely that it is not timely filed.

Turn to page 45 to begin a new case.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 1

Review the Resource Book, pages 11 - 13 if you need to. Then return to this page for instructions.

Review the CA-1 submitted by Roger C. Bass on pages 65 - 66 and answer the questions on page 67.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Bass Roger C		2. Date of Birth 2-1-50	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number 019-16-7922	
5. Employee's Home Mailing Address (No., street, city, state, zip code) 716 Kent Road Pikesville, Maryland 21104			6. Home Telephone Area Code 301 Number: 609-5149
7. Name and Address of Employing Agency U S Post Office 7284 Pratt Street BALTIMORE, MD 60103		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) Opening Belt - 3rd work floor Pratt Street Post Office	
9. Date and Hour of Injury (mo., day, year) <input checked="" type="checkbox"/> AM 7/6/83 7 10 <input type="checkbox"/> PM	10. Date of This Notice (mo., day, year) 7/6/83	11. Dependents Wife/Husband <input checked="" type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation Mailhandler
13. Cause of Injury (Describe how and why the injury occurred) While leaning forward to loosen jammed mail on the conveyor belt, I hit my right knee on the metal cross bar brace		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) Bruised right knee	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;"><u>Roger C Bass</u> Signature of Employee or Person Acting on His/Her Behalf</div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)	

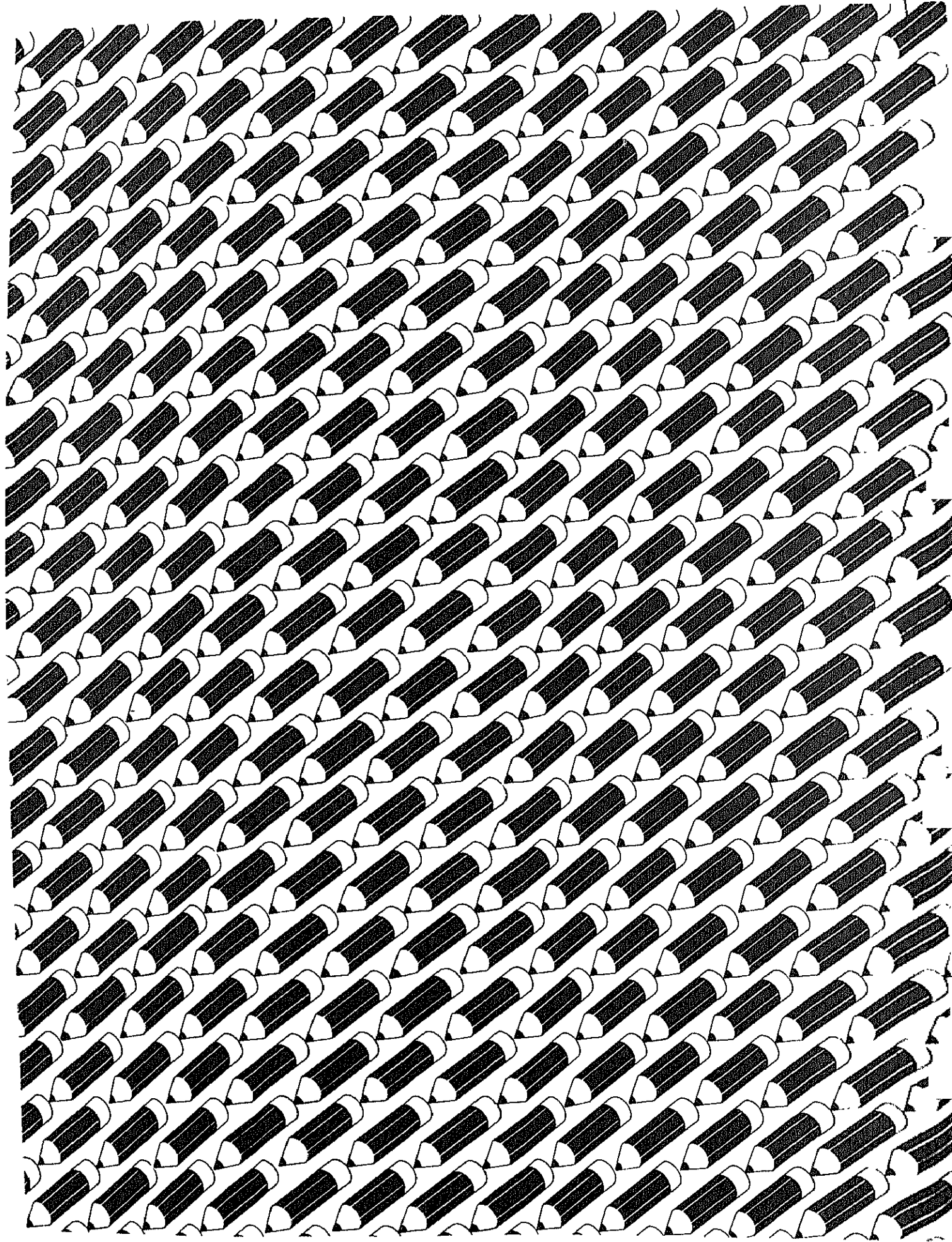
OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY				
21. Department or Agency <i>U S Postal Service</i>		22. Bureau or Office <i>Pratt Street Post Office</i>		
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>7284 Pratt Street BALTIMORE, MD 60103</i>				
24. Regular Work Day Begins <i>6:30</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends <i>3:00</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week <i>(S) (M) (T) (W) (T) F S</i>	
27. Date and Hour of Injury (mo., day, year) <i>9/6/83 7:10</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>9/6/83</i>	29. Date and Hour Stopped Work (mo., day, year) <i>9/6/83 7:30 PM</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year) <i>N/A</i>	
31. 45 Day Period Begins (mo., day, year) <i>9/7/83</i>	32. Pay Rate When Employee Stopped Work <i>\$ 21.096 per hr</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <i>9/10/83 6:30</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor At Time of Injury <i>C E. Thomas</i>	
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.				
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.				
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.				
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>9/6/83</i>	39. Name and Address of Physician First Providing Medical Care <i>Vincent P Haines 1108 Benson Road Columbia, MD 21062</i>		40. Do Medical Reports Show Employee Is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If No, Furnish A Detailed Explanation. <i>I don't understand how the employee could bump his knee on the metal cross bar brace.</i>				
42. Does The Employing Agency Controvert Continuation of Pay? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.				
43. Signature of Supervisor <i>C. E. Thomas</i>	44. Title and Office Phone Number <i>Supervisor, Harbo 9624</i>		45. Date (mo., day, year) <i>9/1/83</i>	

TASK BOOK
CONTROVERSION
BASS CASE
TASK 1

The supervisor has indicated in box 41 that he disagrees with the employee's statement, but provides little information. State three requests or questions you might ask of the supervisor. Write the questions below.

WHEN YOU HAVE WRITTEN YOUR QUESTIONS, TURN TO PAGE 68 FOR THE ANSWER.

END OF TASK MATERIAL



TASK BOOK
CONTROVERSION
BASS CASE
TASK 1

Answer:

Your request to Supervisor Thomas might contain any of the following points:

- a. Please clarify your statement "I don't understand how the employee could bump his knee on the metal cross bar brace."
- b. Please provide me with a detailed drawing of the conveyor belt. The diagram should be detailed, have labeled parts, and be easily understandable to the laymen. Please include any pertinent dimensions.
- c. Were any other employees working on the belt with Mr. Bass at the time of injury? If so, have them provide a statement as to whether or not they witnessed the injury.
- d. Was Mr. Bass' behavior or physical condition in any way different from the norm for the 40 minutes he worked prior to the injury?

GO ON TO NEXT PAGE.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 2

Review the following statements you have received from Supervisor Thomas and witness Older and the diagram shown on page 72. Then complete the task on page 73.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 2

William I. Garcon
Injury Compensation Supervisor
Pratt Street Post Office
7284 Pratt Street
Baltimore, MD. 60103

Below is my itemized response to the questions you raised in your 9/8/83 memorandum:

- 1) The metal cross bar brace on which Mr. Bass alleges he struck his knee runs parallel to the floor and 10 inches above it. This is the only metal cross bar brace on the conveyor belt. Since mailhandler Thomas is 5'9" tall, it would be virtually impossible for him to strike his knee on the brace unless he was crouched down on both knees. To the contrary, Mr. Bass states he was leaning forward reaching across the machine to loosen jammed mail when he struck the knee. In this position it is impossible that he could strike the knee on the metal cross bar brace.
- 2) Enclosed is a diagram of the opening belt conveyer. I have identified the metal cross bar brace, given you the location of the individuals involved and also shown the position of the jammed mail on the belt.
- 3) Mailhandler Richard E. Older was approximately six feet away from Mr. Bass loading mail onto the belt. I have attached a copy of Mr Older's statement. This is a relatively quiet piece of equipment and conversation at six feet is audible.
- 4) I didn't notice anything unusual about Mr. Bass on the morning of injury. He showed none of the obvious signs of physical discomfort such as limping. He was on duty for only 40 minutes before the injury occurred.
- 5) I am not aware of any other factors pertinent to the merit of this claim. Mr. Bass drives a motorcycle to work and does play basketball.
- 6) Before I became a supervisor, I worked on the conveyer belt for eleven years. I know of no other employee ever injured in the manner described by Mr. Bass.

C. E. Thomas
Supervisor, Mails
Pratt Street Post Office

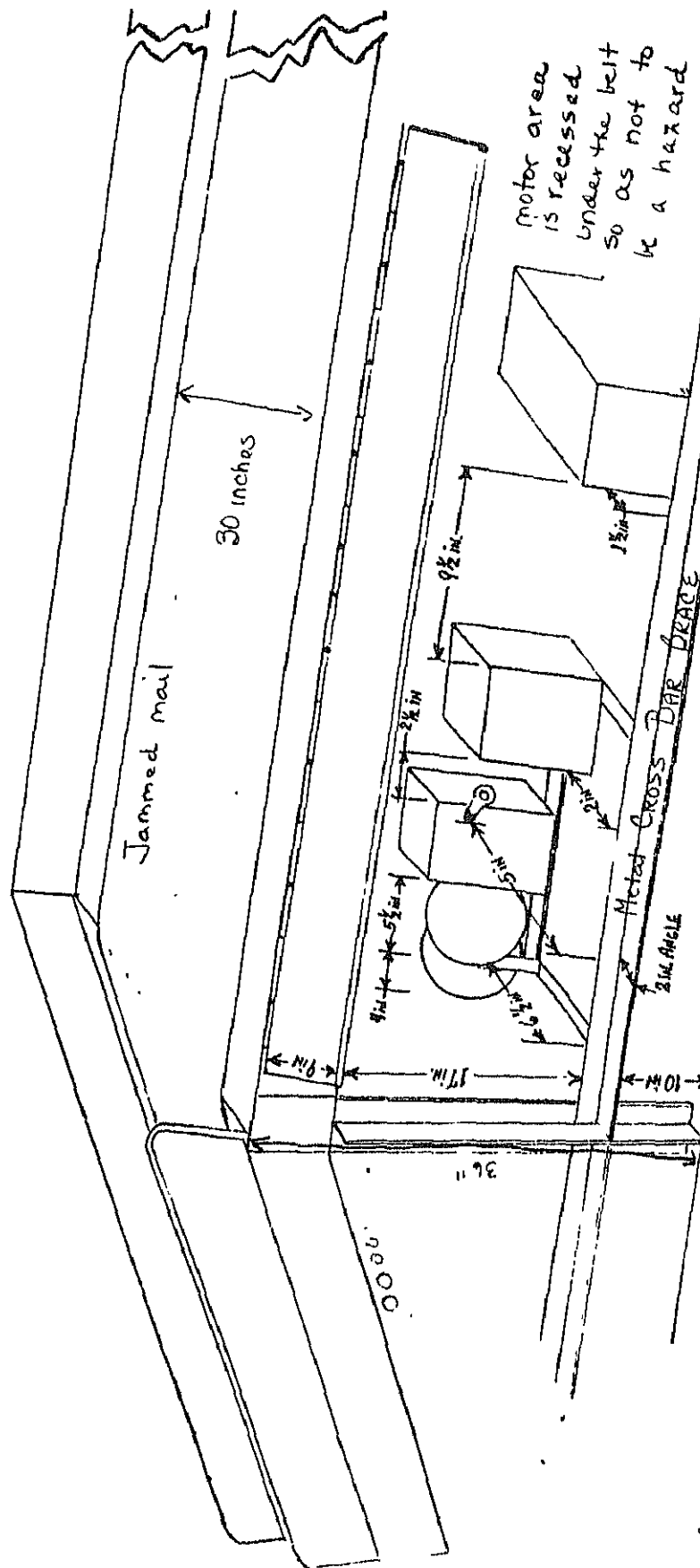
Attachments

TASK BOOK
CONTROVERSION
BASS CASE
TASK 2

TO: Supervisor C. E. Thomas
Pratt Street Post Office

On 9/6/83 at approximately 7:25 a.m. while working on #3 opening conveyor belt, I noticed Roger was limping. I asked him what happened and he told me that he bumped his knee a few minutes ago. I did not hear him holler or ask for help when it happened. This is all I know.

Richard E. Older
Mailhandler



Mailhandler Richard E. Older
loading mail on conveyor
approximately six foot
away from Mr Bass

Position where Mr Bass FLOOR
was standing

1.30.77
L.L.H.

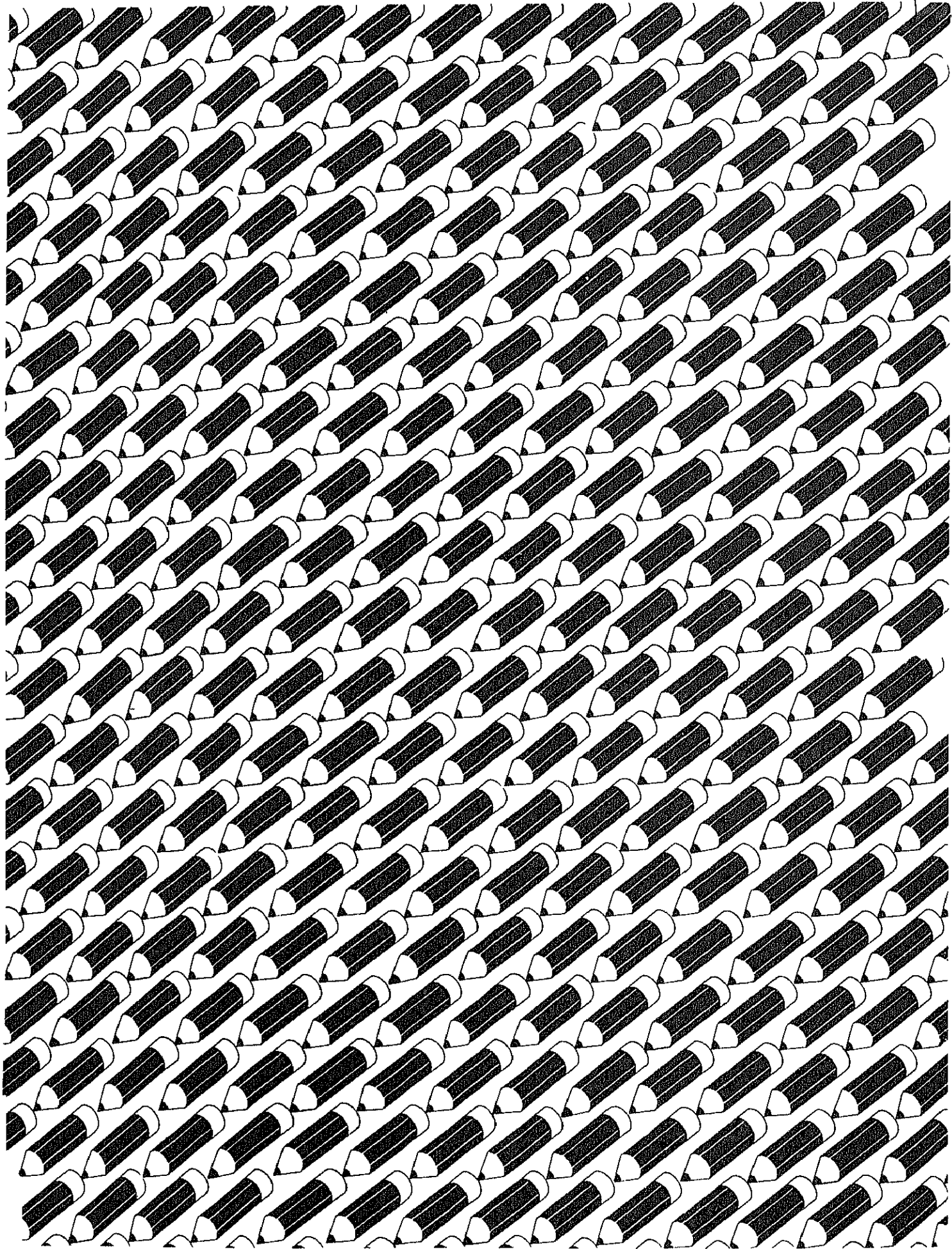
TASK BOOK
CONTROVERSION
BASS CASE
TASK 2

After reviewing the documents you have decided you need to ask the claimant some specific questions. You might wish to review the resource material on pages 11 - 13 of the Resource Book.

In the space below, write out at least four questions you would ask the claimant.

WHEN YOU HAVE FINISHED, TURN TO PAGE 74 TO CHECK YOUR ANSWERS.

END OF TASK MATERIAL



Answer:

The questions you might ask the claimant would include:

- a. How did the injury occur? Give details.
 1. The corner bar brace is only 10" high. It appears that a man of your height would have had to slip or be in a squatting position to hit your knee. Are you sure you didn't slip?
 2. Did anything hit you from behind that would cause you to hit your knee?

You should ask the claimant the following questions, since OWCP will ask them anyway. To not supply the answers could hold up action on the claim.

- b. Were there any persons who witnessed your injury or had immediate knowledge of it?
- c. What were the immediate effects of the injury and what did you do immediately thereafter?
- d. Was any other injury sustained, either on or off duty, between the date of injury and the date it was first reported to (a) your supervisor and (b) to a doctor? If so, describe:
- e. Did you have any similar disability or symptoms before the injury? If so, describe the prior condition. Give the names and addresses of the physicians who treated you and the approximate dates you were treated:
- f. Did you ever file a claim for workers' compensation benefits from any source? If so, give the date and nature of the injury, the name and address of the office where the claim was filed, and describe the benefits (if any) which you received.

TURN THE PAGE FOR THE NEXT TASK.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 3

Read the answers to your questions from the claimant on the following pages (76 and 77).

STATEMENT

1. Describe in detail exactly how the injury occurred.
 - A. I was working on the conveyor belt on September 6, 1983. When I leaned across to loosen some jammed mail, I hit my right knee on the metal cross bar brace.
 - a. The corner bar brace is only 10" high. It appears that a man of your height would have had to slip or be in a squatting position to hit your knee. Are you sure you didn't slip?
 - A. No, I didn't slip. I was stretching across the conveyor belt. When I took a slight step forward to reach across I hit my knee.
 - b. Did anything hit you from behind that would cause you to hit your knee?
 - A. Nothing hit me from behind.
2. Give the names of any persons who witnessed your injury or had immediate knowledge of it.
 - A. There were no witnesses who saw the accident.
3. State the immediate effects of the injury and what you did immediately thereafter.
 - A. My knee was hurting so bad, I told my supervisor I wanted to go to the doctor, so I went to my family doctor. He sent me home to put ice on my knee.
4. Was any other injury sustained, either on or off duty, between the date of injury and the date it was first reported to (a) your supervisor and (b) to a doctor? If so, describe:
 - A. No.

(continued on next page)

TASK BOOK
CONVERSION
BASS CASE
TASK 3

Statement (continued)

5. Did you have any similar disability or symptoms before the injury? If so, describe the prior condition. Give the names and addresses of the physicians who treated you and the approximate dates you were treated.

A. No.

6. Did you ever file a claim for workers' compensation benefits from any source? If so, give the date and nature of the injury, the name and address of the office where the claim was filed, and describe the benefits (if any) which you received.

A. No.

/ Roger C Bass

Roger C. Bass

GO ON TO NEXT PAGE.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 3

On the basis of the claimant's answers, you decide to controvert the case. With that in mind, answer question a and turn to the page indicated.

- a. Circle the number of the statement below which describes the grounds for controverting the case.
1. Failure to establish fact of injury. Turn to page 107, Box 1.
 2. The condition is an occupational disease. Turn to page 80, Box 4.
 3. The injury occurred off the employing agency's premises and the claimant was not involved in official duties. Turn to page 106, Box 3.
 4. The claim was not timely filed. Turn to page 79, Box 2.

(If you need to review the grounds for controverting a claim, they are on pages 28 - 31 of the Resource Book.

- b. Would you terminate COP? (Refer to the rules for controverting COP on pages 26 - 27 in the Resource if you need to.)
1. Yes. Turn to page 169, Box 4.
 2. No. Turn to page 142, Box 2.

1

Correct. This is the preferable course of action. This case is not controvertible due to the fact that the employee was involved in a fight over equipment at work. The fight arose out of the employment factors.

Now turn to page 51 for the next case.

2

No. There is no evidence that the claim was not timely filed.

Return to page 78 for another choice.

3

The Emergency Room report will not help because it is connected with the reported injury of lifting mail sacks.

Return to page 62 and select again.

4

No. Work limitations should be requested later.. However, until you resolve the question of whether the disability is job-related, it is not really relevant.

Return to page 57 and try again.

1

It is true that a complete medical report is needed and it must include what treatment was given for the 7/8 injury. However, this is not the most basic question.

Return to page 57 and select another answer.

2

No. The description of the claimant, supervisor and medical report are consistent. The dates also match. There is no ground for questioning job relatedness.

Now return to page 49 and try a different answer.

3

No. Even though the claimant was acutely intoxicated, it did not cause the injury. The Emergency Room report is connected with the reported injury of lifting mail sacks.

Return to page 62 and select a different answer.

4

No. There is no evidence of an occupational disease.

Return to page 78 for another choice.

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

If you need to, review the Resource Book pages 28 - 33.

Review the CA-1 and CA-16 submitted on behalf of Sally A. Roberts on pages 82 - 85. Focus on what steps you would take with the case. After your review of those documents go on to page 86 which details next developments in the case.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) <i>Roberts, Sally A</i>		2. Date of Birth <i>2-11-56</i>	3. <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
		4. Social Security Number <i>806-14-5407</i>	
5. Employee's Home Mailing Address (No., street, city, state, zip code) <i>711 Mountain Road Cockeysville, MD 21030</i>		6. Home Telephone Area Code: <i>301</i> Number: <i>222-6081</i>	
7. Name and Address of Employing Agency <i>US Postal Service 900 E Hayette St Baltimore MD 21233-9998</i>		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) <i>2nd work floor - Operation 110</i>	
9. Date and Hour of Injury (mo., day, year) <i>2/27/84 3:50</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	10. Date of This Notice (mo., day, year) <i>2/27/84</i>	11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation <i>Mail handler</i>
13. Cause of Injury (Describe how and why the injury occurred) <i>Harassment by supervisor over being late for work. Letter of warning issued to me</i>		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) <i>Nerves</i>	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay. 			
16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;"><i>Sally A Roberts</i> _____ Signature of Employee or Person Acting on His/Her Behalf</div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury) <i>None</i>			
18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)	

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY			
21. Department or Agency USPS		22. Bureau or Office Balto Md	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) USPS - Rm 217 900 E Fayette St. Balto MD 21233-9408			
24. Regular Work Day Begins 3:30 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM Ends 12:00 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		25. Number of Hours Worked Per Day 8	26. Circle Days Paid Per Week (S) (M) T (W) (T) (F) S
27. Date and Hour of Injury (mo., day, year) 2/27/84 3:50 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) 2/27/84	29. Date and Hour Stopped Work (mo., day, year) 2/27/84 3:50	30. If Pay Has Been Terminated, Give Date (mo., day, year) N/A
31. 45 Day Period Begins (mo., day, year) 2/28/84	32. Pay Rate When Employee Stopped Work \$ 16.036 per yr	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM HAS NOT RETURNED	34. Name of Supervisor at Time of Injury Wm X Black
35. Was Employee in Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for the Injury (mo., day, year) 2/27/84	39. Name and Address of Physician First Providing Medical Care Dr Michael R. Green 301 South Eutaw St Balto MD 21234		40. Do Medical Reports Show Employee Is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated. Attach Additional Sheets If More Space Is Needed.			
43. Filing Instructions <input type="checkbox"/> No Lost Time and No Medical Expense, Place this Form in Employee's Official Personnel Folder <input checked="" type="checkbox"/> Medical Expense Incurred or Expected, Forward this Form to OWCP <input checked="" type="checkbox"/> Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP			
44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ (Fill in Date)			
45. Signature of Supervisor Wm X Black	46. Title and Office Phone Number Supvr. Maiba	47. Date (mo., day, year) 922-4930	

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A - AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

DR Michael R. Green
301 South Eutaw St
Baltimore MD 21234

2. EMPLOYEE'S NAME (Last, first, middle)

Roberts, Sally A

3. DATE OF INJURY
(mo., day, year)

2/27/84

4. OCCUPATION

Mail handler

5. DESCRIPTION OF INJURY OR DISEASE

Employee alleges anxiety reaction over being
disciplined for lateness

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

- ☐ A. FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.
- ☒ B. THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)

Patricia L. Short

9. TITLE

Injury Comp Super.

10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER

922-4901

11. DATE (mo., day, year)

2/27/84

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.

Dept. or Agency

715 PS

Bureau or Office

Baltimore Md.

Local Address
(Including Zip Code)

900 E Fayette St
Baltimore Md 21233-9408

PART B - ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle) <i>Roberts, Sally A</i>						
15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU? <i>"Became emotionally upset over disciplinary action for lateness". Supervisor harasses me</i>						
16. IS THERE ANY HISTORY OR EVIDENCE OF PRE EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>No Roberts suffers from a paranoid mental disorder as a result of head trauma 2 yrs ago</i>						
17. WHAT ARE YOUR FINDINGS (include results of x rays, laboratory tests, etc.)? <i>anxiety reaction</i>			18. WHAT IS YOUR DIAGNOSIS? <i>Paranoid mental disorder</i>			
19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>May have been exacerbated by her P.O. job</i>						
20. DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, date of admission (mo., day, year) Date of discharge (mo., day, year)			21. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
22. SURGERY (if any, describe type) <i>N/A</i>			23. DATE SURGERY PERFORMED (mo., day, year)			
24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? <i>Counseling psycho-therapy</i>			25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?			
26. DATE OF FIRST EXAMINATION (mo., day, year) <i>2/27/84</i>	27. DATE(S) OF TREATMENT (mo., day, year) <i>2/27/84</i>		28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year) <i>Has not</i>			
29. PERIOD OF DISABILITY (if termination date unknown, so indicate) (mo., day, year) TOTAL DISABILITY FROM <i>2/27</i> TO <i>Unknown</i> PARTIAL DISABILITY FROM TO		30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year) LIGHT WORK <i>N/A</i> REGULAR WORK				
31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FURNISH DATE ADVISED (month, day, year)						
32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS						
33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED						
34. DO YOU SPECIALIZE? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state specialty) <i>Psychiatrist</i>						
35. SIGNATURE OF PHYSICIAN <i>L.M.R. Green</i>		36. ADDRESS (Number, street, city, state, zip code) <i>301 S. Euteria St Baltimore, Md. 21234</i>		37. PHYSICIAN'S SOCIAL SECURITY NUMBER <i>108-16 3601</i>		
				38. DATE OF REPORT (mo., day, year) <i>2/28/84</i>		
39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.						
Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price		Amount	
			Cost	Per	\$	c
	TOTAL					

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

The supervisor checked "no" in block 41 of the CA-1, indicating his disagreement with the employee's description of the injury. But he did not furnish a detailed explanation. You request a written statement from him.

You also request a written statement from the claimant detailing the injury suffered.

Finally, you consult the Official Personnel File (OPF) for any similar incident in the past.

Review your notes from the OPF, statements from the claimant and the supervisor on pages 87 - 89.

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

Your check of the personnel file reveals three letters of warning issued to Ms. Roberts in the past. Your notes summarizing these letters are:

- 1) Letter dated 12/4/83 - Given for lateness by supervisor Black
- 2) Letter dated 8/12/83 - Given for lateness by supervisor Johnson
- 3) Letter dated 4/8/83 - Given for lateness by supervisor Johnson

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

STATEMENT

On February 27 I got a letter from my supervisor that upset me so much that I had to see my doctor. Mr. Black threatened to suspend me. He terrified me so much that my nerves are shot. After I got the letter I tried to do my work, but I couldn't concentrate. I felt sick to my stomach and dizzy and couldn't stop crying. I went back to my supervisor and told him I wanted to see my doctor. I'm afraid to go back to work there. I just don't know what will happen next.

He's been hard on me all along, but now I know he's out to take my job away from me. I thought those other letters were mean and unnecessary. I believe he has been much harder on me than he should have been.


Sally A. Roberts

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

STATEMENT

On 2/27/84 I issued a Letter of Warning to mailhandler Sally A. Roberts for lateness. In the past month Ms. Roberts has been late on seven different occasions. Prior to issuing the letter of warning, I had personalized private discussions with Ms. Roberts on 2/10/84 and again on 2/24/84 concerning her tardiness. I impressed on Ms. Roberts the importance of being punctual in that all scheduling is done within the first 15 minutes of the shift. Replacements are secured for employees who do not report and then, manpower overages occur when employees finally do report later in the tour. It was hoped that by explaining the scheduling process to Ms. Roberts she would be more conscientious in her efforts to report to work on time. Unfortunately, this did not occur. The first occasion that she was late after our 2/24/84 discussion was on 2/26/84 and I felt it necessary to give her a letter of warning on 2/27/84.

The Letter of Warning stated that continued lateness would not be tolerated and further instances would result in more severe disciplinary action such as suspension. The letter was discussed with Ms. Roberts in a private setting and at the end of our conversation she appeared to be completely rational.

Approximately 20 minutes later Ms. Roberts returned to my office in a highly agitated state. She stated that I was harrassing her and that she wanted to see her private doctor. At that point, I authorized her to go to the Medical Unit.

For the record, Ms. Roberts has received a personal Letter of Warning from me in the past year. At that time it did not result in her having an anxiety attack.

s/William Black

William X. Black
Supervisor, Mails

TURN THE PAGE.

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

Based on your review of these documents, circle the letter in front of one or more of the following steps listed below that you would take:

- a. Request that the claimant re-submit the claim on a CA-2
- b. Controvert the claim on the basis of failure to establish fact of injury.
- c. Process the claim (don't controvert) on the basis of medical condition of an aggravation.
- d. Controvert the claim on the basis that it is an occupational disease claim, not a traumatic injury.
- e. Withhold any action until you have received a fully detailed medical report including a complete diagnosis and sound medical opinion that the medical condition is job related.
- f. Controvert the claim on the basis of pre-existing condition not related to work.
- g. Controvert COP.

WHEN YOU HAVE MADE YOUR SELECTION(S) TURN TO PAGE 91 TO
COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

Answer:

You should have circled items a, d, and g, (Request that the claimant re-submit the claim on a CA-2, controvert the claim on the basis that it is an occupational disease claim, not a traumatic injury, and controvert COP)

You have a case for controversion on the basis that this is an occupational disease claim. Even though Sally Roberts did not react violently to previous letters of warning, the cause of her symptoms was the underlying environmental condition (alleged harrassment) which has been going on for 10 months. As a result it is an occupational disease, not a traumatic injury.

You would therefore terminate COP and request that she submit a CA-2.

- b. The fact of injury (anxiety attack) is admitted by supervisor as claimed.
- c. An aggravation may indeed turn out to be the case after sufficient medical evidence is developed since the attending physician indicates this. However, it is still probably an occupational disease case and the traumatic injury claim with COP should be controverted.
- e. Sure a medical report should be requested, but on the evidence you judge that it is an occupational disease case, you should not wait before taking steps a, d, and g.
- f. Even though a pre-existing condition is present, the doctor indicates that there may be an aggravation which would be compensable.

YOU HAVE FINISHED THE MODULE ON CONTROVERSION.

IF YOU WISH TO CONTINUE NOW, TURN THE PAGE TO BEGIN A NEW MODULE.

MODULE III

THIRD PARTY

As in the previous modules, you will be given a case and a series of tasks. For the case in this module you will be asked to:

- a. Make an initial decision about the case on the basis of the information given, and
- b. Compute or evaluate any additional information.

TURN THE PAGE TO DO THE CASE ON THIRD PARTY LIABILITY.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 1

First read the Resource Book, pages 35 - 36 (through No. 10)

Then review the following CA-1 to determine if there is possible third party liability. Go to page 96 to answer the question.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Williams, Arlene S	2. Date of Birth 6-17-40	3. <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	4. Social Security Number 128-14-7010
5. Employee's Home Mailing Address (No., street, city, state, zip code) 893 McCullough Street, BALTIMORE, MD 21015		6. Home Telephone Area Code: 301 Number: 646-1983	
7. Name and Address of Employing Agency U S Postal Service 1900 E Fayette Street Baltimore, MD 21233		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) Intersection of 8th and Market Street	
9. Date and Hour of Injury (mo., day, year) <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM 6/10/83 2:15	10. Date of This Notice (mo., day, year) 5/16/83	11. Dependents Wife/Husband <input checked="" type="checkbox"/> Children Under 18 Years Old <input checked="" type="checkbox"/>	12. Employee's Occupation Letter Carrier
13. Cause of Injury (Describe how and why the injury occurred) Stopped at the intersection of 8th and Market Street when a truck drifting backwards hit the front of my vehicle.		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) neck sprain	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay. I was taken from the accident scene to the hospital Then I was home on bedrest Today is my first day back to work			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: right; margin-right: 100px;">Arlene S Williams</div> <div style="text-align: right; margin-right: 100px;">Signature of Employee or Person Acting on His/Her Behalf</div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)	

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency <i>U S Postal Service</i>		22. Bureau or Office <i>Baltimore, Maryland</i>	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>1900 East Fayette Street Baltimore, Md 21233</i>			
24. Regular Work Day Begins <i>6:00</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends <i>2:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week S <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> F S
27. Date and Hour of Injury (mo., day, year) <i>5/10/83 2:15</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>5/10/83 (Verbal)</i>	29. Date and Hour Stopped Work (mo., day, year) <i>5/10/83 2:15 P.M.</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year) <i>N/A</i>
31. 45 Day Period Begins (mo., day, year) <i>5/11/83</i>	32. Pay Rate When Employee Stopped Work <i>\$ 22.040 per hr</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM <i>5/16/83 8:30</i>	34. Name of Supervisor At Time of Injury <i>Mae L. Harts</i>
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>5/10/83</i>	39. Name and Address of Physician First Providing Medical Care <i>Union Hospital 409 Greenway Avenue Baltimore, Maryland 21110</i>		40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item B of Instruction Sheet). Attach Additional Sheets If More Space is Needed.			
43. Signature of Supervisor <i>Mae L. Harts</i>	44. Title and Office Phone Number <i>Supervisor, Delivery 252-6048</i>		45. Date (mo., day, year) <i>5/16/83</i>

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 1

Circle the letter of the choice below that most nearly describes what the indicator of third party liability in this case is:

- a. The cause of the injury was defective equipment for which the manufacturer may be responsible. Turn to page 142, Box 3.
- b. You always know that it is a third party case if there is an automobile accident. Turn to page 107, Box 2.
- c. There is no indicator of third party liability. Box 37, "Was Injury Caused by Third Party? was checked NO. Turn to page 141, Box 3.
- d. The indicator is the statement made on the CA-1, block 13 which says "a truck drifting backwards hit the front of my vehicle". Turn to page 106, Box 4.

THIRD PARTY
WILLIAMS CASE
TASK 2

How would you verify that there is, in fact, third party liability? Again, circle the letter of the statement that best describes your answer and turn to the page indicated next to your answer.

- a. Interview the driver of the other vehicle to get the facts about the injury. Turn to page 107, Box 3.
- b. Interview any witnesses to the accident and get statements about what they saw. Turn to page 141, Box 4.
- c. Get the police report to see if the driver of the truck was cited by the police as being responsible for the accident. Turn to page 106, Box 1.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 3

Read the Resource, pages 36 - 40.

You have obtained the police report. It says that the truck driver was cited for the accident and there is nothing to indicate any contributory negligence.

The agency is now pursuing this claim. Review the following correspondence on the case from pages 99 - 104.

Then do the task on page 105.

UNITED STATES POSTAL SERVICE
MANAGEMENT SECTIONAL CENTER
BALTIMORE, MD. 21233
May 17, 1983

Ms. Arlene A. Williams
893 McCullough Street
Baltimore, MD 21015

Dear Ms. Williams:

Our records show that on May 10, 1983 you sustained an injury under circumstances which may place liability for damages on a party other than the United States.

Under the provisions of Section 8131 of Title 5, United States Code, the Secretary of Labor can and will require a workers' compensation beneficiary to prosecute an action for damages in his/her own name when injury or death occurs under circumstances which indicate legal liability to pay damages on a party other than the government. When damages are recovered from such a party, the beneficiary must, out of the damages recovered, reimburse the United States for any payments made to the beneficiary or on the beneficiary's behalf. Nevertheless, in all cases you will be entitled to a minimum of 20% of the net recovery.

For our records a statement is required from you as to whether you have presented a claim for damages as a result of this injury against anyone other than the Postal Service or the Office of Workers' Compensation Programs. It is requested that you answer the questions on the attached form, Third Party Claim-Information Request, and promptly return it to this office.

If you have initiated a third-party action, you should contact us for a statement of any COP and OWCP disbursements made to you or on your behalf before you make a final settlement. These disbursements must be repaid from any recovery you make from the third party (the person or persons responsible for the injury).

If you wish to discuss this matter or desire us to assist you, please contact me on 938-6012.

Sincerely,

Mary Y. Elliott
Injury Compensation Supervisor.

U.S. POSTAL SERVICE INJURY COMPENSATION PROGRAM — NOTICE OF POTENTIAL THIRD PARTY CLAIM (See instructions on reverse)		1 DATE 5-24-83
2 Name of Employee Arlene S Williams	4 Home Address (Include Apt No and ZIP Code) 893 McLough Street Baltimore Md. 21215	
3 Home Phone (Include Area Code) (301) 646-1983		
5 Type of Injury Motor Vehicle Accident	6 Date and Location of Injury 5-16-83 8th and Market Street Baltimore Md. 21233	
7 Office of Employment U S Postal Service	8 Employee's Title Letter Carrier	
9 Contact Point at Employing Office (Name and Phone) Mae L. Marts 352-6048		10 Employee's Social Security No 128-14-7010
11 Prepared by (Printed Name and Signature) Arlene S Williams		12 OWCP File No A25-169803
13 Brief Description of Incident While stopped at intersection of 8th and Market a truck drifting backwards hit the front of the mail vehicle.		
14 Does the Employee or Beneficiary(ies) intend to take action against the Third Party? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If "No", specify why not)		
15 Third Party a. Name Larry R. Wilson		b. Address (Include Apt No and ZIP Code) 1108 15th Street Baltimore Md. 21215
c. Name and Address of Insurance Company (Include Suite No.) Ashley Insurance Co. P.O. Box 6128 Baltimore Md. 21151		16 Name and Address of Attending Physician (Apt /Suite No.) Dr Alexander Gee Union Hospital 409 Greenway Ave. Balt. Md. 21106
17 Law Enforcement Agency Notified Baltimore Police Dept.		18 Name and Address of Attorney representing employee in Third Party Action (Include Apt /Suite No.) 21110
19 EMPLOYEE OR REPRESENTATIVE		
Wage records, medical records, and other pertinent information may be released to my attorney <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
a. Date Signed 5/24/83	b. Printed Name Arlene S Williams	c. Signature Arlene S. Williams

PS Form
Mar. 1981 2582

U.S. POSTAL SERVICE
ASSIGNMENT OF CLAIM TO THE USPS

As a result of my applying for and receiving benefits under the provisions of the Federal Employees' Compensation Act (5 U.S.C. 8101-50), and because I do not wish to prosecute an action in my own name to recover damages, I (name) Arlene S. Williams, of (address) 893 McCullough Street, City of Baltimore, County of _____, State of Md., hereby voluntarily assign to the United States Postal Service all of my right, title and interest in any claim, demand, or cause of action which I may have against (name of third party) Larry R. Wilson, or any other person, as a result of an injury I sustained on (date) 5/16/83, at (location) 8th and Market Street Baltimore Md. while in the performance of my duties as an employee of the United States Postal Service.

I understand that in the event of recovery of damages by the United States Postal Service under this assignment, I am entitled to one-fifth of the net amount of recovery after the expenses thereof have been deducted and to any surplus remaining as provided by Section 8131 of the Federal Employees' Compensation Act.

I understand that I have the right to pursue an action to recover damages by myself or by an attorney of my own choice, but I hereby am assigning that right to the United States Postal Service. Upon acceptance of this assignment, the United States Postal Service shall have full and complete authority to take whatever action on this claim it considers appropriate, and may institute legal action, settle or compromise the claim or any suit, or decline to institute suit, or to take any other action.

I hereby authorize the United States Postal Service to furnish all records, medical and other reports, statements made by myself and other papers relating to my injury to the parties against whom claim is made, their representatives, and insurance companies for the purpose of effectuating a settlement of the assigned claim.

IN WITNESS WHEREOF, I have signed this assignment this 24th day of May, 1983.

Arlene S. Williams
(Signature)

Pursuant to the authority granted by 39 C.F.R. 224.2(b) (1) (i) and other Postal Regulations, I hereby accept the above assignment.

Dated 5-25-84

Henry J. Elliott
(Signature)

Injury Compensation Sup.
(Title)

UNITED STATES POSTAL SERVICE
MANAGEMENT SECTIONAL CENTER
BALTIMORE, MD. 21233

May 25, 1983

Mr. Larry R. Wilson
1108 15th Street
Baltimore, MD 21015

Dear Mr. Wilson:

On 5/10/83, a postal employee, Arlene S. Williams, was injured as a result of your truck drifting backwards into the front of her postal vehicle.

Pursuant to the provisions of the Federal Employees' Compensation Act, our employee has filed for benefits and has assigned her personal injury claim to the Postal Service. A copy of that assignment is attached.

We request that you, your insurance carrier, or your attorney contact this office to discuss settlement of this matter.

Sincerely,

Mary Y. Elliott
Injury Compensation Supervisor.

UNITED STATES POSTAL SERVICE
MANAGEMENT SECTIONAL CENTER
BALTIMORE, MD. 21233
June 15, 1983

TO: Mae L. Marts, Supervisor, Delivery
USPS
1900 E. Fayette Street
Baltimore, MD 21233

SUBJECT: Third Party Claim

Employee: Arlene S. Williams
OWCP Claim No.: A25-169803
Date of Injury: 5/10/83

Please be advised that we anticipate negotiating settlement with respect to the captioned case in the near future. Therefore, it is requested that you discuss this matter with the employee to determine if there are any expenses, other than those listed below, that were incurred as a result of this injury, which the employee wishes taken into consideration at the time of settlement. Such expenses may include pain and suffering, damage expenses not covered by COP or FECA benefits.

If any such expenses exist, please furnish this office an itemized statement by 6-28-83 so that we may fully document our file before any settlement negotiations are finalized.

Your cooperation in this matter is appreciated.

Sincerely,

Mary Y. Elliott
Injury Compensation Supervisor

MEDICAL AND RELATED EXPENSES:

Name of Provider:	Amount:
Union Hospital	\$ 184.00
Dr. Alexander Gee	\$ 110.00
Prescriptions	\$ 15.84
Cervical Collar	\$ 11.00
Subtotal	\$ 320.84

CONTINUATION OF PAY:

	Amount:
From: 5/11/83	
To: 5/15/83	\$ 342.68

OTHER:

DISBURSEMENTS MADE BY THE
OFFICE OF WORKERS' COMPENSATION PROGRAMS
AND BY THE EMPLOYING AGENCY
JULY 18, 1983

NOTE: ADDITIONAL PAYMENTS MAY BE MADE. THEREFORE, PLEASE
CONTACT THIS OFFICE FOR AN UP-TO-DATE STATEMENT PRIOR TO
FINAL SETTLEMENT OF THE THIRD PARTY ACTION.

CLAIMANT: Arlene S. Williams
FILE NO: A25-680139
DATE OF INJURY: 5/10/83

CONTINUATION OF PAY

From: 5/11/83 To: 5/15/83 \$ 342.68

Subtotal \$ 342.68

COMPENSATION PAYMENTS

From: To: \$

Subtotal \$

MEDICAL AND RELATED EXPENSES

Name of Provider

Amount

Union Hospital	\$ 184.00
Dr. Alexander Gee	\$ 110.00
Prescriptions	\$ 15.84
Cervical Collar	\$ 11.00

Subtotal \$ 320.84

DISBURSEMENTS TO DATE \$ 663.52

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 3

Prior to figuring the lien, you review the file and notice that an important piece of information is missing from the file. Circle the letter of the item that is missing from the file and read the page indicated for the answer.

- a. Correspondence to the third party explaining the accident and asking that responsible party, insurance carrier or their attorney contact the workers' compensation office to discuss the case. Turn to page 107, Box 4.
- b. A statement from OWCP providing itemization of disbursements made on behalf of the claim. Turn to page 142, Box 4.
- c. Correspondence to the employee's supervisor requesting that she ask the employee if there are any expenses other than those you list in that letter that were incurred as a result of the injury which the employee wants included in the settlement. Turn to page 106, Box 2.
- d. Response from the employee's supervisor indicating if there are any other expenses that the employee incurred. Turn to page 141, Box 1.

1

Correct. Get the police report to see if the driver of the truck was cited by the police as being responsible for the accident. If he were, this would clearly determine liability.

NOW, IF YOU WORK FOR THE U. S. POSTAL SERVICE OR ANOTHER AGENCY THAT HAS ARRANGED WITH OWCP TO PURSUE ITS OWN CLAIMS, TURN TO PAGE 98 TO CONTINUE THIS CASE. IF YOUR AGENCY DOES NOT PURSUE ITS OWN CLAIMS, GO ON TO PAGE 114 TO BEGIN THE MODULE ON LIGHT DUTY. IF YOU DO NOT WORK FOR THE USPS AND YOU ARE NOT SURE IF YOUR AGENCY HAS SUCH AN AGREEMENT, ASSUME THERE IS NONE AND GO TO PAGE 115.

2

No. This correspondence is in the file.

Return to page 105 for another try.

3

No. Even though you may conclude that it was impossible for the injury to occur as the claimant described, you have no evidence that the injury resulted from an off-premises injury.

Return to page 78 for another try.

4

Correct. The best answer is "the statement made on the CA 1." There appears to be third party liability, even though the question in block 37 was checked "no". It appears that the driver of the truck is responsible for the accident and the resulting injury to the letter carrier.

Turn to page 97 for the next task.

1

Correct. The grounds are failure to establish fact of injury (#1).

Return to page 78 and answer question b.

2

No, although an automobile accident can mean third party liability, that is not always the case. This has to be checked out. In this case, the claimant's statement on the CA-1 gives you an indicator that there may be third party liability.

Return to page 97 and try again.

3

No. The driver of the other vehicle may be willing to be interviewed by you, but even if he does, would the results be considered objective?

Return to page 97 for another try.

4

No. that is in the file.

Return to page 105 for another try.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 4

You have received the piece of missing information. It follows on page 109.

From it and the information in the file figure:

a. The lien

\$ _____

b. The projected settlement figure

\$ _____

AFTER YOU HAVE ARRIVED AT YOUR ANSWER, COMPARE YOURS WITH THE ANSWER ON PAGE 110.

MEMORANDUM
June 20, 1983

TO: Mary V. Elliott
Injury Compensation Supervisor

FROM: Mae L. Marts
Supervisor, Delivery

SUBJECT: Employee: Arlene S. Williams
OWCP Claim No.: A25-169803
Date of Injury: 5/10/83

response to your request regarding expenses incurred as a
result of her injury, Ms. Williams has itemized the expenses
as follows:

MEDICAL AND RELATED EXPENSES:

Name of Provider:	Amount:
Union Hospital	\$ 184.00
Dr. Alexander Gee	\$ 110.00
Prescriptions	\$ 15.84
Cervical Collar	\$ 11.00
Subtotal	\$ 320.84

CONTINUATION OF PAY:

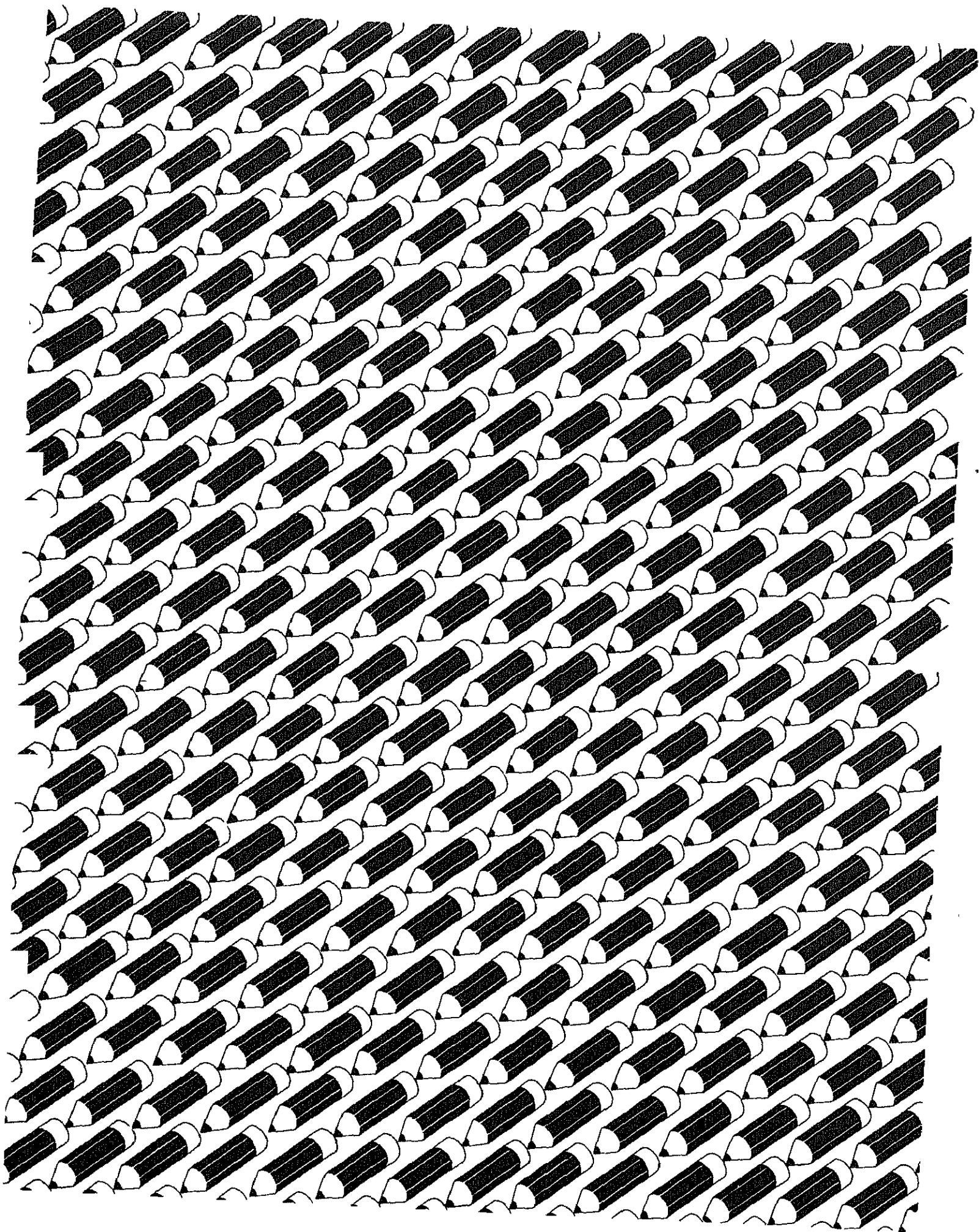
From:	Amount:
5/11/83	
To: 5/15/83	\$ 342.68

OTHER

Transportation:	
5/11/83 hospital to home	\$5.00
Day care for daughter:	
5/10/83 to 5/11/83 - 1 1/2 days	
@ \$20.00/day	\$30.00

TOTAL \$35.00

END OF TASK MATERIAL



TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 4

Answer:

- a. Lien is \$698.52 (or \$699)

This is taken from the Disbursements notification by OWCP - \$663.52 plus expenses incurred by the employee submitted on the memo from the employee's supervisor - \$35.00. Total of these two figures equals \$698.52.

- b. Projected settlement figure is \$2,096.

This was arrived at by multiplying the lien of \$698.52 times 3 since this is a minor injury. Total of this is \$2,095.56. Round it up to the nearest dollar to get \$2,096.

TURN THE PAGE AND DO THE LAST TASK FOR THIS CASE.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 5

Using the figures from the previous task, complete the Statement of Recovery on page 112. Instructions for completing this Statement of Recovery are on page 113.

WHEN YOU HAVE COMPLETED THE FORM, COMPARE YOUR FIGURES WITH THOSE IN THE BOOK ANSWER ON PAGE 114.

STATEMENT OF RECOVERY

Claimant:

File Number:

Date of Injury/Death:

Employing Agency:

(1) Gross Recovery	\$ _____
(2) Less Property Damage	_____
(3) Balance	_____
(4) Less Attorney's Fee (Fee is _____% of line 3)	_____
(5) Balance	_____
(6) Less Court Costs (must be itemized)	_____
(7) Balance (Adjusted Gross Recovery)	_____
(8) Less 1/5 (20% of line 7)	_____
(9) Balance	_____
(10) Continuation of Pay (COP)	_____
(11) Balance	_____
(12) Less Payment to Public Health Service (or other Federal medical facility)	_____
(13) Balance	_____
(14) Less Medical Expenses Paid by the Claimant (must be itemized)	_____
(15) Balance	_____
(16) OWCP Disbursements (including compensation and medical but excluding COP) or line 15 above, whichever is less	\$ _____
(17) Less Government Allowance for Attorney's Fee (retained by claimant)	_____
(18) Net OWCP Refund	_____
(19) Plus Continuation of Pay (line 10)	_____
(20) Total Refund	_____
(21) Surplus (line 15 less line 16)	_____

Form CA-162
Rev. August 1980

INSTRUCTIONS

Distribution must be made in accordance with 5 U.S.C. 8132.

PROPERTY DAMAGE (Line 2) A reasonable amount for clothing or other personal belongings damaged or destroyed in an accident may be deducted. These amounts should be itemized. If an automobile or other vehicle is damaged or destroyed, then more tangible evidence of such damage is required. The year, make and model, and the Blue Book value of the vehicle should be furnished. A copy of the repair bill will suffice if the vehicle was not totally destroyed.

ATTORNEY'S FEE (Line 4) The attorney's fee in line 4 is deducted from the balance shown in line 3. Also, the attorney's fee as a percentage of line 3 should be shown.

COURT COSTS (Line 6) These would consist only of such items as filing fees, witness fees, actual costs of collection, or any payments to physicians for expert testimony as opposed to payment for treatment. (Payment for medical treatment would come under line 12 and/or 14.) All items must be itemized.

20% GUARANTEE (Line 8) This amount is turned over to the claimant and is not subject to any deductions.

CONTINUATION OF PAY (COP) (Line 10) If pay was continued by the employing agency as provided by 5 U.S.C. 8118, the employing agency is entitled to be reimbursed out of any third party recovery resulting from the employment-related injury. The OWCP will collect the COP as the agent of the employing agency.

PUBLIC HEALTH SERVICE (Line 12) Refund made to a Federal medical facility for medical treatment would be deductible under line 12. The claim of the Federal medical facility is separate and apart from the claim of the OWCP.

MEDICAL EXPENSE PAID DIRECT (Line 14) This would consist of any medical expenses paid by the claimant other than those paid by the OWCP or by an insurance carrier. It would not include items paid by the claimant for which the claimant subsequently was reimbursed by the OWCP or an insurance carrier. All items submitted for credit and deduction in line 14 must be itemized or accompanied by copies of paid bills. A lump sum amount will not be accepted for credit.

GOVERNMENT ALLOWANCE FOR ATTORNEY'S FEE (Line 17) The Government contributes a portion of its refund to the claimant as an attorney's fee. This fee is based upon the OWCP's disbursements or other amount as shown in line 16 and is computed by applying the percentage shown in line 4 to line 16 if line 4 is considered reasonable.

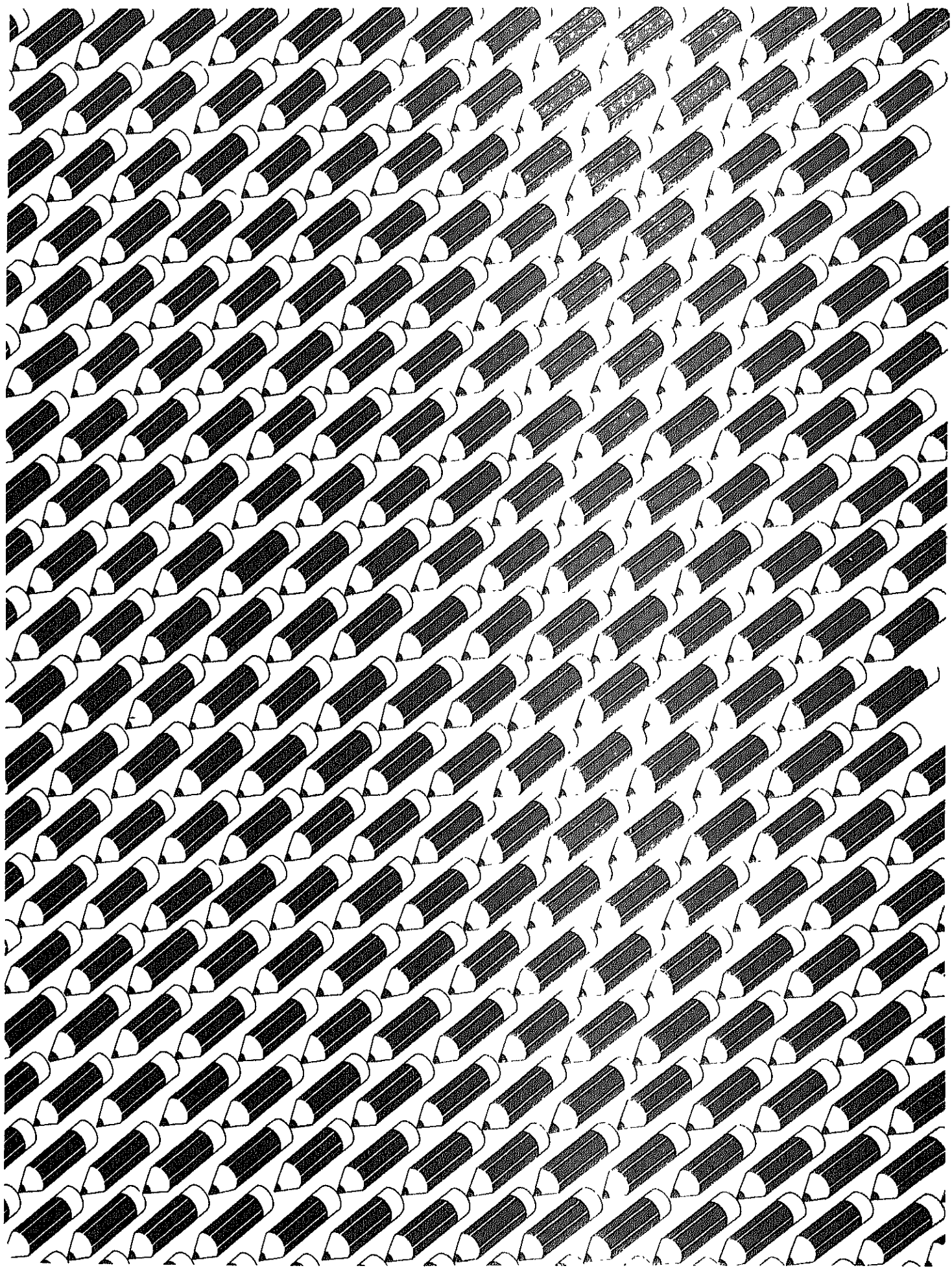
NET OWCP REFUND (Line 18) The full amount of OWCP's disbursements is subject to the refund provisions of the Federal Employees' Compensation Act. However, if the balance remaining in line 15 is less than the actual OWCP disbursement, then the refund provisions would apply to the amount shown in line 15.

TOTAL REFUND (Line 20) This represents the amount to be refunded to the Government for OWCP disbursements and continuation of pay (COP), if any, by the employing agency under 5 U.S.C. 8118. The refunded COP will be forwarded to the employing agency by the OWCP.

SURPLUS (Line 21) This surplus, which is retained by the claimant, is the amount against which the OWCP will credit any future compensation payments or additional medical expenses payable on account of the same injury or death.

The refund check for the amount shown in line 20 should be made payable to "U.S. Department of Labor, OWCP".

END OF TASK MATERIAL



ANSWER:

STATEMENT OF RECOVERY
(see reverse for instructions)

Claimant: Arlene S Williams

File Number: A 25-68013

Date of Injury/Death:

Employing Agency: USPS

(1) Gross Recovery	\$ 2096.00
(2) Less Property Damage	-
(3) Balance	2096.00
(4) Less Attorney's Fee (Fee is _____ % of line 3)	-
(5) Balance	2096.00
(6) Less Court Costs (must be itemized)	-
(7) Balance (Adjusted Gross Recovery)	2096.00
(8) Less 1/5 (20% of line 7)	419.20
(9) Balance	1676.80
(10) Continuation of Pay (COP)	342.68
(11) Balance	1334.12
(12) Less Payment to Public Health Service (or other Federal medical facility)	-
(13) Balance	1334.12
(14) Less Medical Expenses Paid by the Claimant (must be itemized)	-
(15) Balance	1334.12
(16) OWCP Disbursements (including compensation and medical but excluding COP) or line 15 above, whichever is less	\$ 320.84
(17) Less Government Allowance for Attorney's Fee (retained by claimant)	-
(18) Net OWCP Refund	320.84
(19) Plus Continuation of Pay (line 10)	342.68
(20) Total Refund	663.52
(21) Surplus (line 15 less line 16)	\$ 1013.28

TURN THE PAGE TO BEGIN A NEW MODULE

MODULE 4

LIGHT DUTY

As in the previous modules, you will be given a case and a series of tasks. For each case you will be asked to:

- a. Make one or more decisions**
- b. Decide whether or not to place the claimant in a light duty position, and**
- c. If so, what kind of position.**

TURN THE PAGE TO BEGIN THE FIRST CASE.

MODULE 4

LIGHT DUTY

As in the previous modules, you will be given a case and a series of tasks. For each case you will be asked to:

- a. Make one or more decisions**
- b. Decide whether or not to place the claimant in a light duty position, and**
- c. If so, what kind of position.**

TURN THE PAGE TO BEGIN THE FIRST CASE.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

Read the Resource Book, pages 43 - 47.

Review the medical report on page 117 from Dr. Lawhorn concerning Jack A. Davidson. Jack has been off work for over a year due to a job-related injury and is receiving compensation for total temporary disability from OWCP. Also review the physical requirements of his carpenter's job on page 118. Then go to the worksheet on page 119 and do the task.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

Phillip D. Lawhorn, M. D.
Orthopedics
201 East Main Street
Muscle Shoals, Alabama

March 22, 1984:

RE: Jack A. Davidson

Jack returns today as scheduled. He states he has been doing well and has little pain unless he uses his left arm a great deal. Examination reveals a well-healed shoulder scar at the site of the surgical repair of his torn rotator cuff. His range of motion is limited. I believe Jack has reached a maximum point of recovery from his shoulder injury and would estimate 25° ppi to the left upper extremity. I told Jack he should try to find work he could perform with limited use of his left arm and no working above shoulder level. He may return as needed.

S/ Phillip D. Lawhorn, M.D.

Phillip D. Lawhorn, M. D.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

JOB DESCRIPTION
CARPENTER
(with maximum physical requirements)

Carpenter uses hand tools to build forms, scaffolds, partitions, and other wood structures.

Pushing/Pulling	1 hour per day
Sitting	3 hours per day
Walking	3 hours per day
Lifting	3 hours per day*
Bending	1 hour per day
Squatting	1 hour per day
Climbing	1 hour per day
Kneeling	1 hour per day
Standing	3 hours per day
Working Above Shoulder	1 hour per day

- * Lifting 0 -20 lbs = 2 hours per day
- * Lifting 20 - 50 lbs = 1 hour per day
- * Lifting 50 - 100 lbs = 1 time per day

Position requires ability to grasp with both hands and a general good dexterity in both hands.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

- a. Given the work limitations specified, is he able to perform his regular job? Check the best answer below.

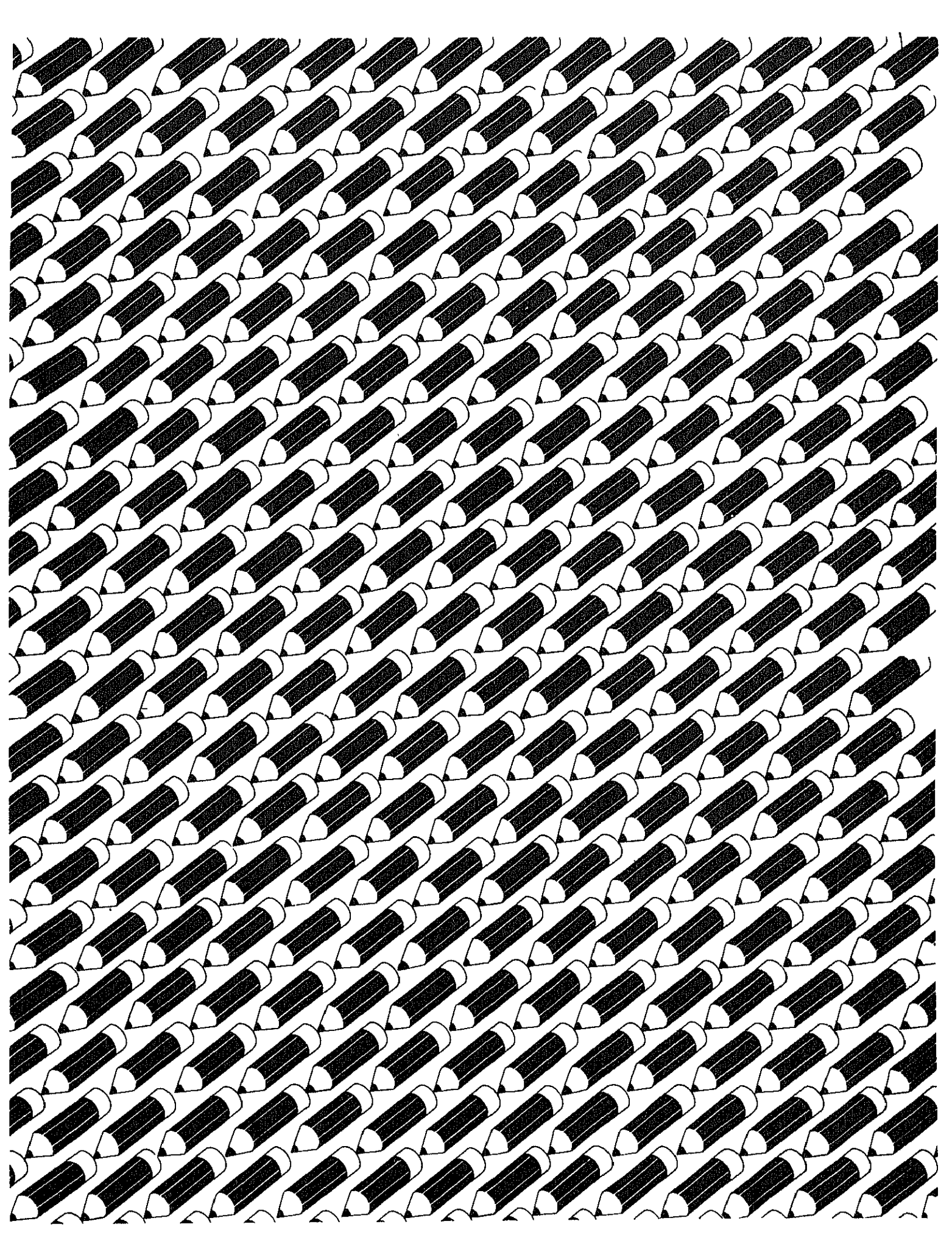
Yes _____ No _____

- b. If your answer is no, circle the number next to any of his duties listed below that conflict with the stated work limitations.

- | | |
|----------|------------------------|
| 1. _____ | Climbing |
| 2. _____ | Kneeling |
| 3. _____ | Standing |
| 4. _____ | Working Above Shoulder |

TURN TO PAGE 120 TO COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

Answer:

a. No

b.

- | | | |
|----|-----------------|------------------------|
| 1. | <u> </u> | Climbing |
| 2. | <u> </u> | Kneeling |
| 3. | <u> </u> | Standing |
| 4. | <u> X </u> | Working Above Shoulder |

TURN THE PAGE AND DO THE NEXT TASK.

.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 2

Mr. Davidson's supervisor informs you that there is a carpenter shopkeeper position open and they would like to have someone who is familiar with carpentry tools and duties. The job pays less than a carpenter rate.

Review the maximum physical requirements that he has provided you with on the following page.

ASE

JOB DESCRIPTION
CARPENTER SHOPKEEPER
(with maximum physical requirements)

Shopkeeper is responsible for keeping all carpenter's
in order and maintaining proper inventory records
ols. Sends damaged tools out for repair or
t.

ning/Pulling	1/2 hour per day
ting	5 hours per day
king	3 hours per day
ting	2 hours per day*
ding	1/2 hour per day
atting	1 hour per day
mbing	0 hours per day
eling	1 hour per day
nding	4 hours per day
king Above Shoulder	0 hours per day

ting 0 -20 lbs = 2 hours per day
ting 20 - 50 lbs = 2 times per day
ting 50 - 100 lbs = 0 times per day

requires ability to recognize carpenter's tools and
ired for specific carpenter's duties.

AGE.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 2

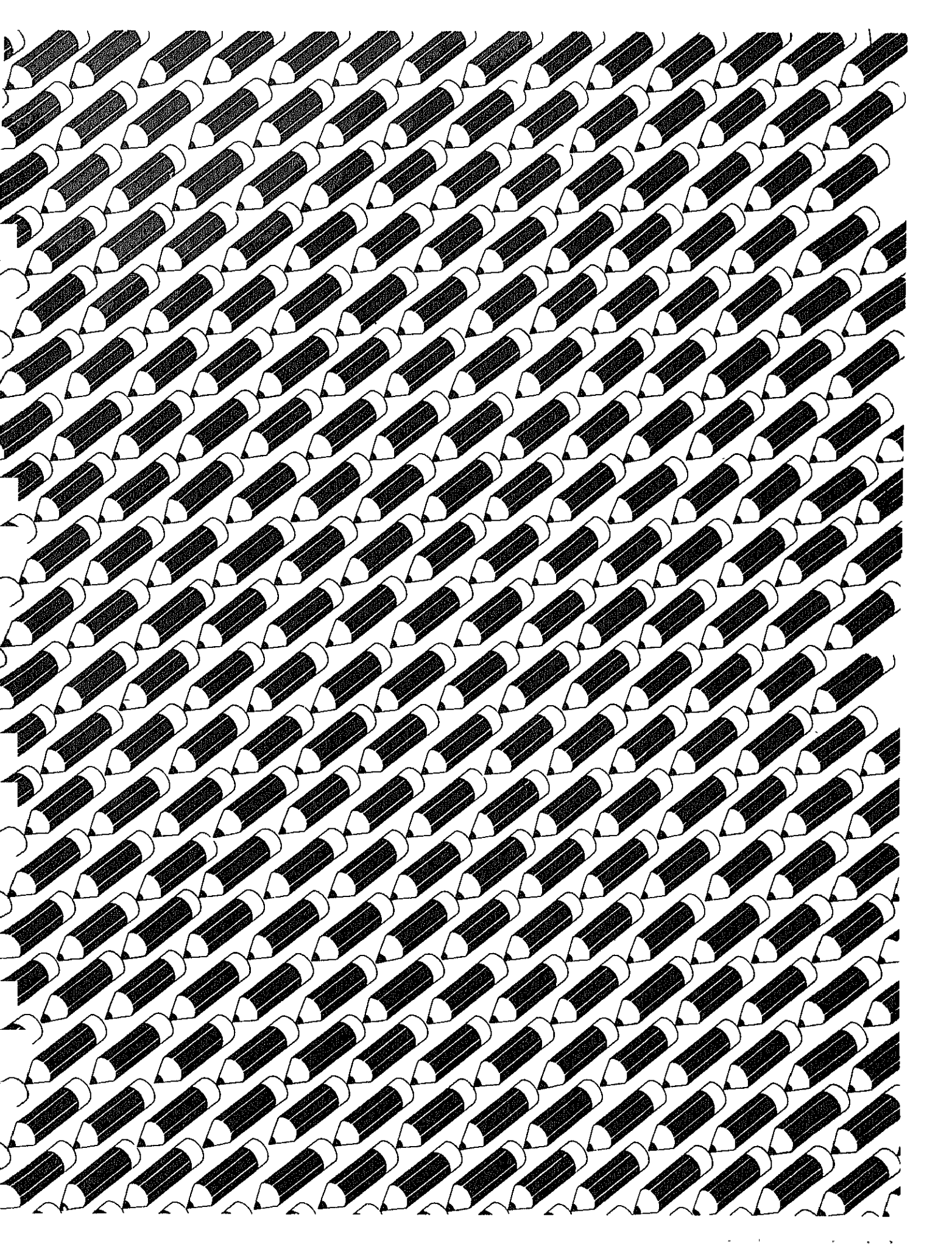
a. Does it appear that Mr. Davidson can perform these duties?

Yes _____ No _____

b. Briefly give your rationale.

AFTER YOU HAVE RECORDED YOUR ANSWERS, TURN TO PAGE 124 AND
COMPARE YOURS WITH THE BOOK ANSWERS.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 2

Answer:

Yes, it appears that he is able to perform the job. However, to be certain, you send Dr. Lawhorn a copy of the maximum physical requirements and a copy of the job description and have him verify in writing whether the work is suitable.

Rationale: Working above shoulder level is not required. Since he is presumably lifting tools, he would not need the use of both hands.

GO ON TO THE NEXT CASE.

TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 1

Refer to the Resource, pages 43 - 47.

Ray Newberry is an electrician who is returning to work after being off work two weeks with a job-related injury.

You know that electricians have to carry equipment and tools, some of which are quite heavy. Beyond that, you don't know of any special job requirements.

Review the physician's note on the following page.

TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 1

March 30, 1984

RE: Ray Newberry

Patient may return to work. He should avoid continuous, heavy lifting and should limit pushing and pulling for 2 weeks.

/s/ Don Thompson M.D.

Don Thompson, M. D.

TURN THE PAGE.

NEWBERRY CASE
TASK 1

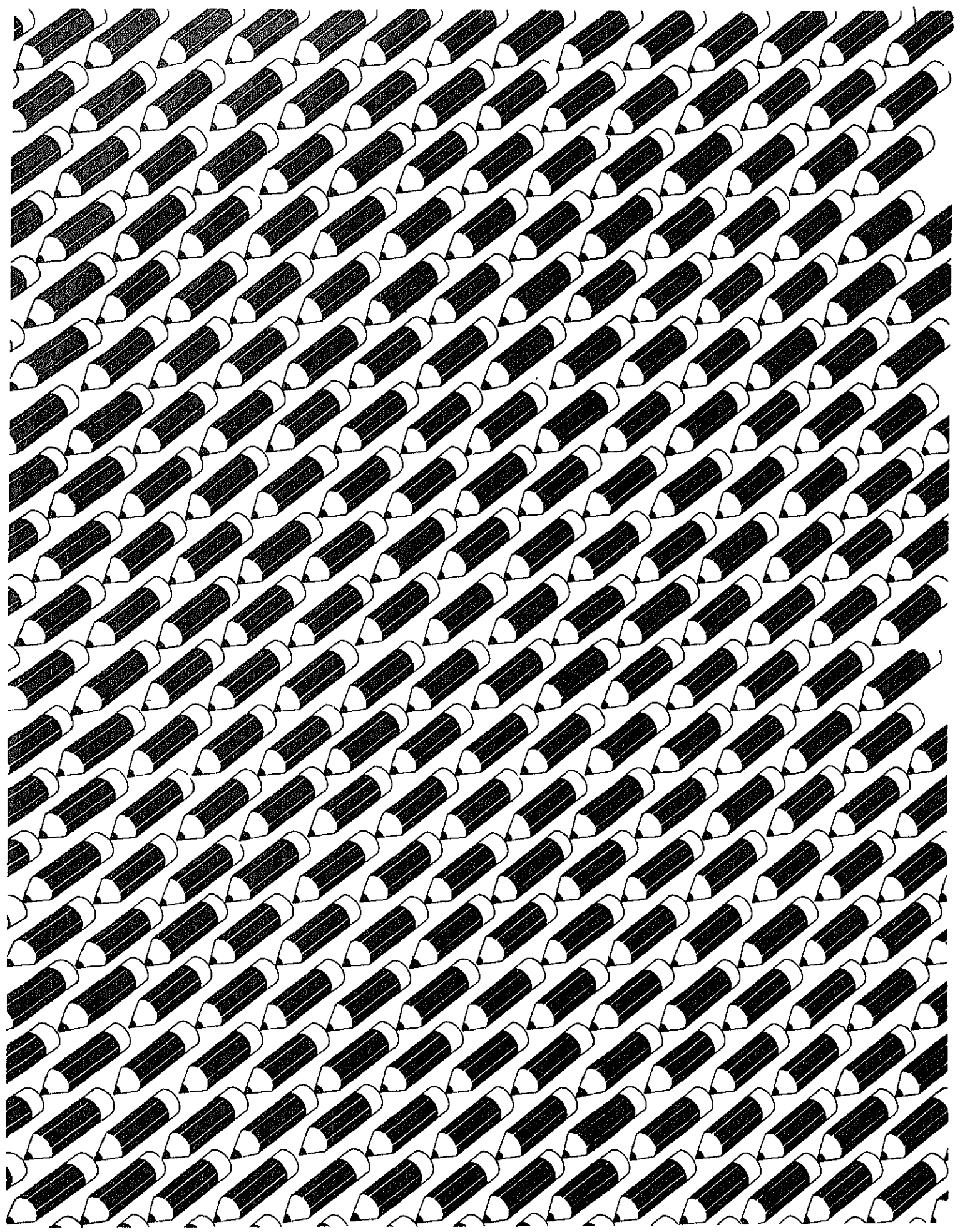
You call Mr. Newberry's supervisor and report the constraints listed in Dr. Thompson's note and ask the supervisor if suitable work is available. Mr. Newberry's supervisor has a reputation for not accepting employees who are limited/restricted. He informs you that he cannot work Mr. Newberry until he is able to perform his regular duties.

TASK:

What 3 questions would you ask of the supervisor to clarify whether the medical constraints conflict with his regular job duties? (The CA-17 defines heavy lifting as lifting from 50 to 100 pounds.) Write your answers below.

AFTER YOU HAVE WRITTEN YOUR ANSWERS, TURN TO PAGE 128 AND READ THE BOOK ANSWERS.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 1

Answer:

Your questions should include the following:

1. What is the heaviest weight your electricians have to lift?
2. Do they have to lift anything over 50 lbs continuously?
3. How much pushing/pulling is required?

GO ON TO THE NEXT TASK.

TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 2

The answers you get to these questions from the supervisor are as follows:

1. Q. What is the heaviest weight your electricians have to lift?
A. The heaviest weight is approximately 50 lbs.
2. Q. How often do they have to lift 50 lbs?
A. Only once a day.
3. Q. Do they have to lift 50 lbs continuously?
A. No. The only thing lifted continuously are hand tools weighing up to 15 or 20 lbs. They might lift those for an hour or two continuously.
4. Q. How much pushing/pulling is required?
A. Only occasionally - maybe once or twice a day.

You and the supervisor informally record these answers during the conversation. The results that you have jotted down are:

Maximum Physical Requirements
Ray Newberry - Electrician

Lifting 0-20 lbs.	Continuous - 2 hours a day
Lifting over 50 lbs	Intermittent and Seldom - 1 time/day
Pushing/Pulling	Intermittent and Seldom - 1 time/day

TURN THE PAGE TO ANSWER THE QUESTION.

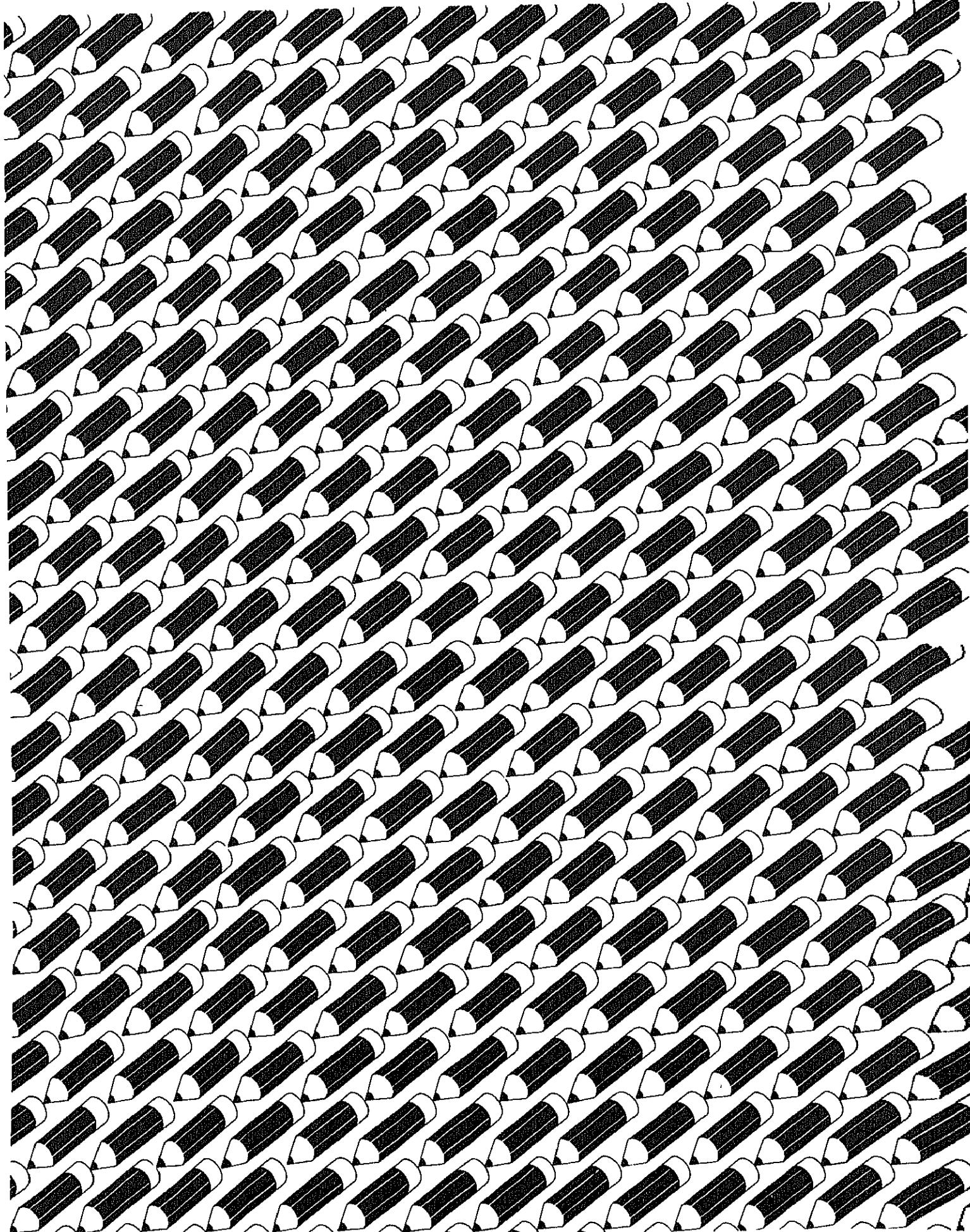
TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 2

Can Mr. Newberry perform his full duties as an electrician without violating his medical constraints? Check your answer below.

Yes No

AFTER YOU HAVE WRITTEN YOUR ANSWER, COMPARE IT WITH THE BOOK ANSWER ON PAGE 131.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 2

Answer:

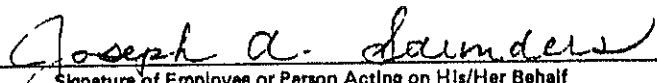
Yes. Regular duties will not require that he do any continuous heavy lifting - he would lift heavy weight only intermittently once a day. Also, regular work will not require him to push or pull more than once a day.

TURN THE PAGE AND DO THE NEXT CASE.

LIGHT DUTY
SAUNDERS CASE
TASK 1

On the following pages (133 - 139) review the CA-1 for Joseph Saunders, Dr. Right's CA-17 dated 1/13/84, and the light duty job descriptions.

Select the light duty assignment that best meets the work limitations for Joseph Saunders. Then go to the worksheet on page 140.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Saunders, Joseph A.		2. Date of Birth 3/21/49	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number 012-64-3011	
5. Employee's Home Mailing Address (No., street, city, state, zip code) 704 E. Spencer St Baltimore Md. 21231		6. Home Telephone Area Code: 301 Number: 436-7052	
7. Name and Address of Employing Agency U.S. Postal Service 900 E. Fayette Street Baltimore, Md. 21233-9408		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) in front of 354 Vermont Street.	
9. Date and Hour of Injury (mo., day, year) <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM 1-3-84 9:00 PM	10. Date of This Notice (mo., day, year) 1-3-84	11. Dependents Wife/Husband <input checked="" type="checkbox"/> Children Under 18 Years Old <input checked="" type="checkbox"/>	12. Employee's Occupation Lettercarrier
13. Cause of Injury (Describe how and why the injury occurred) Fell on icy pavement and hurt my back		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) injured lower back in fall	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;"> Signature of Employee or Person Acting on His/Her Behalf</div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)	

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY				
21. Department or Agency U.S. Postal Service		22. Bureau or Office Baltimore		
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) U.S. Postal Service 900 E. Fayette St., Balt Md. 212339408				
24. Regular Work Day Begins 7:30 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends 4:00 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day 8	26. Circle Days Paid Per Week S (M) (T) (W) (T) (F) S	
27. Date and Hour of Injury (mo., day, year) 1-3-84 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM 3:00	28. Date Reporting Office Received Notice of Injury (mo., day, year) 1-3-84	29. Date and Hour Stopped Work (mo., day, year) 1-3-84 3:00pm	30. If Pay Has Been Terminated, Give Date (mo., day, year) N/A	
31. 45 Day Period Begins (mo., day, year) 1-4-84	32. Pay Rate When Employee Stopped Work \$2240 ² per yr	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor At Time of Injury Thomas Wilson	
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.				
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.				
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.				
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) 1-3-84	39. Name and Address of Physician First Providing Medical Care Louis S. Right M.D. 1313 St Paul Place Baltimore, MD. 21230		40. Do Medical Reports Show Employee Is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.				
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item 8 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.				
43. Signature of Supervisor Thomas S. Wilson		44. Title and Office Phone Number Supervisor 254-9676		45. Date (mo., day, year) 1-3-84

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A - SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Louis S Right, M.D.
1313 St Paul Place
Baltimore, MD 21230

2. EMPLOYEE'S NAME (Last, first, middle)

Saunders, Joseph A

3. DATE OF INJURY
(Mo., day, year)

11/3/84

4. OCCUPATION

Letter Carrier

5. SOCIAL SECURITY NUMBER

012-64-3011

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Fell on icy pavement, injured low back

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD 5 hours - NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDENTARY - LIFTING 0 to 10 POUNDS
LIGHT - LIFTING 10 to 20 POUNDS
MODERATE - LIFTING 20 to 50 POUNDS
HEAVY - LIFTING 50 to 100 POUNDS
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:

LITTLE OR NONE	MODERATE	OFTEN
		} 5 hours
none		5 hours
		3 hours
		5 hours
		2 hours
none		
little		
none		
little		
1 hour		
none		

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

U.S. Postal Service
900 E Fayette Street
Baltimore MD 21233-9408

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

PART B - PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in Item 7)? ☐ YES ☒ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME ☐ FULL TIME Date (Mo., day, year)
Hours a day

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☒ YES, IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. (Including Preexisting Conditions.)

PHYSICAL LIMITATIONS

SEDENTARY - LIFTING 0 to 10 POUNDS
LIGHT - LIFTING 10 to 20 POUNDS
MODERATE - LIFTING 20 to 50 POUNDS
HEAVY - LIFTING 50 to 100 POUNDS
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (1 HOURS)
STANDING (1 HOURS)
SITTING (8 HOURS)
STOOPING (0 HOURS)
KNEELING (0 HOURS)
REPEATED BENDING (0 HOURS)
CLIMBING (0 HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:
EXPOSURE LIMITATIONS (Specify):

FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
✓		
✓		
✓		
✓		
✓		
✓		
	✓	
	✓	
		✓
✓		
✓		
✓		
		✓

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY (If termination date unknown, so indicate)

TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM 1/3/84 TO continuing

14. DATE EMPLOYEE ABLE TO RESUME WORK (Mo., day, year)

LIGHT WORK ☒ 1/3/84
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☒ YES ☐ NO. IF YES, FURNISH DATE ADVISED (Mo., day, year)

1/3/84

16. DIAGNOSIS OF CONDITION DUE TO INJURY

lumbo sacral strain

17. DATE OF EXAMINATION

1/3/84

18. DATES OF FURTHER APPOINTMENTS, IF ANY

1/17/84

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

Louis S. Righie, M.D.

20. PROFESSIONAL DEGREE

M.D.

21. DATE (Mo., day, year)

1/3/84

TASKBOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

JOB DESCRIPTION

Office Clerk

Physical Requirements: Ability to use both hands. No lifting, bend stopping, climbing, reaching above shoulders required. Ability to do limited walking/standing preferred but not required.

Environmental Factors: Office work. Sedentary using a swivel chair with arm and backrests. Elevation of limbs as well as canes and crutches permissible.

Proficiency: General office work. Handwriting and alphabetizing skills preferred. Some use of office equipment such as xerox machines.

Schedule: Off days: Saturday/Sunday
Reporting time: 6:00 a.m. to 8:30 a.m. on the half hour

Available
Assignments:

Zip Code Unit	Rm 512	6:00 a.m.
Centralized Forms	Rm 407	6:30 a.m.
Medical Unit	Rm 326	7:00 a.m.
Personnel	Rm 509	7:30 a.m.
Certification/Testing	Rm 302	8:00 a.m.
Claims and Tracers	Rm 517	8:30 a.m.

TASKBOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

JOB DESCRIPTION

Mark-Up Clerk

Physical Requirements: Ability to lift 10 pounds. Chiefly sedentary work with the ability to do limited walking, standing, bending and twisting. No squatting, climbing or kneeling. No work above shoulder level. Must have one good arm preferably the one they write with.

Environmental Factors: Factory environment. Sitting in a chairback drafting stool with no armrests. Elevation of limbs, canes, crutches, and open toed shoes not allowed.

Proficiency: Mark up address corrections and manually file the corrected mail. Handwriting and ability to file mail by zip code required.

Schedule: Off days: 2 days to be negotiated; this is a 7 day-a-week operation

Reporting Time: 24 hour a day operation - hours to be negotiated

Assignment: Centralized Mark-Up Unit, Room 208

TASK BOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

JOB DESCRIPTION

File Clerk

Physical Requirements: Ability to lift 25 pounds. Primarily standing work with ability to do limited sitting. Bending, twisting, and reaching above shoulders required. No squatting, climbing or kneeling. Must have one good arm.

Environmental Factors: Factory environment. Standing and filing mail with the ability to do limited sitting on a stool. No arm or backrest available. Elevation of limbs, canes, crutches, and open-toed shoes not allowed.

Proficiency: Ability to file mail by zip code.

Schedule: 24 hour a day, 7 day a week operation. Two off-days to be negotiated.

Assignment: Main Post Office, second floor, operation 430.

TASK BOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

On the choices below, circle the letter in front of the job that best meets Mr. Saunders' work limitations. Then turn to the page indicated next to your choice.

a. Office clerk. Turn to page 161, Box 4.

b. Mark-up clerk. Turn to page 142, Box 1.

c. File clerk. Turn to page 141, Box 2.

1

Correct. The file is missing (d) - a response from the employee's supervisor indicating if there are any other expenses that the employee incurred. You cannot figure the lien without this response.

Turn to page 108 to continue the case.

2

No. The file clerk position has physical requirements that exceed work limitations of:

- 1) lifting 25 lbs
- 2) bending
- 3) reaching above shoulder

Return to page 140 and try again.

3

Although the claimant did not claim third party liability, this does not determine liability. You still need evidence.

Return to page 96 and try again.

4

No. It is possible that there were witnesses, and that you could find them to interview, but this would mean a time consuming investigation. There is a better way.

Return to page 97 and make another selection.

1

No. The position of mark-up clerk (choice b.) has physical requirements that exceed his work limitations:

- . ability to lift 10 lbs.
- . bending
- . limited walking and standing may possibly exceed his work limitations.

Return to page 140 and try again.

2

No, you would not terminate COP because fact of injury is not grounds for terminating COP.

Turn to page 81 for the next case.

3

No. There is no evidence of faulty equipment.

Return to page 96 for another try.

4

No. This is in the file.

Return to page 105 for another try.

TASK BOOK
LIGHT DUTY
SAUNDERS CASE
TASK 2

- a. Of the available office clerk assignments which should Mr. Saunders be given? Circle the letter of your choice. Then answer question b. below before turning to the page indicated.

- | | | | |
|----------------------|--------|-----------|-----------------------------|
| 1. Zip Code Unit | Rm 512 | 6:00 a.m. | Turn to page 168,
Box 4. |
| 2. Centralized Forms | Rm 407 | 6:30 a.m. | Turn to page 167,
Box 2. |
| 3. Medical Unit | Rm 326 | 7:00 a.m. | Turn to page 169,
Box 1. |
| 4. Personnel | Rm 509 | 7:30 a.m. | Turn to page 161,
Box 1. |

- b. Briefly state below why you chose the answer you did.

TASK BOOK
LIGHT DUTY
SAUNDERS CASE
TASK 3

Mr. Saunders returned to his treating physician, Louis S. Right, M.D. on 1/17/84 for a follow-up appointment. Review the attached CA-17 dated 1/17/84 and determine if Mr. Saunders is still in the limited duty assignment which best meets his physical restrictions.

If not, use the position descriptions provided in TASK 1 (pages 137 - 139) and think about whether you would reassign him to one of these positions or keep him in the office clerk job.

After reviewing the position descriptions, go to the worksheet on page 147 and answer the questions.

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

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PART A - SUPERVISOR

1 NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Louis S. Riche, M.D.
1313 St Paul Place
Baltimore Md 21230

2 EMPLOYEE'S NAME (Last, first, middle)

Saunders, Joseph A

3. DATE OF INJURY
(Mo., day, year)

1/3/84

4. OCCUPATION

letter carrier

5. SOCIAL SECURITY
NUMBER

012-64-3011

6 DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Fell on icy pavement, injured low back

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD 5 hours NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDFENTARY - LIFTING 0 to 10 POUNDS
LIGHT - LIFTING 10 to 20 POUNDS
MODERATE - LIFTING 20 to 50 POUNDS
HEAVY - LIFTING 50 to 100 POUNDS
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:

LITTLE OR NONE	MODERATE	OFTEN
		5 hours
none		5 hours
		3 "
		5 "
		3 '
none		
little		
none		
little		
1 hour		
none		

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

U.S. PS
900 E Fayette St
Baltimore Md. 21233-9408

INSTRUCTIONS FOR COMPLETION AND
SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

PART B -- PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in item 7)? ☐ YES ☒ NO
(If yes, indicate whether Part or Full Time and date able to resume such work)

☐ PART TIME ☐ FULL TIME Date (Mo, day, year)
Hours a day

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☒ YES IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. (Including Preexisting Conditions.)

PHYSICAL LIMITATIONS

SEDENTARY -- LIFTING 0 to 10 POUNDS

LIGHT -- LIFTING 10 to 20 POUNDS

MODERATE -- LIFTING 20 to 50 POUNDS

HEAVY -- LIFTING 50 to 100 POUNDS

PULLING/PUSHING, CARRYING

REACHING OR WORKING ABOVE SHOULDER

WALKING (4 HOURS)

STANDING (4 HOURS)

SITTING (4 HOURS)

STOOPING (1 HOURS)

KNEELING (1 HOURS)

REPEATED BENDING (1 HOURS)

CLIMBING (0 HOURS)

OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.

OTHER:

EXPOSURE LIMITATIONS (Specify):

FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
		✓
		✓
✓		
✓		
	✓	
	✓	
	✓	
	✓	
	✓	
	✓	
	✓	
✓		
		✓

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY (If termination date unknown, so indicate)

TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM 1/17/84 TO continuing

14. DATE EMPLOYEE ABLE TO RESUME WORK (Mo, day, year)

LIGHT WORK ☒ 1/17/84
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☒ YES ☐ NO. IF YES, FURNISH DATE ADVISED (Mo., day, year)

1/3/84

16. DIAGNOSIS OF CONDITION DUE TO INJURY

resolving lumbosacral strain

17. DATE OF EXAMINATION

1/17/84

18. DATES OF FURTHER APPOINTMENTS, IF ANY

2/17/84

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

Louis S Right

20. PROFESSIONAL DEGREE

MD

21. DATE (Mo., day, year)

1/17/84

DOK
DUTY
IS CASE

nders has shown some improvement. Circle the letter
of the decision you would make at this point regarding
nders' job.

p him in the office clerk job. Turn to page 167, Box

ssign him to the mark-up clerk job. Turn to page 161
3.

ssign him to the file clerk job. Turn to page 168,
2.

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

Review the CA-17 for James Ryan and the job description for Welder, WG-3703-10 on the following three pages. Then do the task on page 152.

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A - SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

SHIPYARD DISPENSARY, NORFOLK, VA.

2. EMPLOYEE'S NAME (Last, first, middle)

Ryan, James Robert

3. DATE OF INJURY
(Mo., day, year)

3/18/83

4. OCCUPATION

Welder

5. SOCIAL SECURITY
NUMBER

349-80-1763

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Fell while climbing vertical ladder on board the America

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT

COLD

NOISE

4-6 hrs

DUST

4-6 hrs

FUMES

6 hrs

STRESS

OTHER

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDENTARY - LIFTING 0 to 10 POUNDS
LIGHT - LIFTING 10 to 20 POUNDS
MODERATE - LIFTING 20 to 50 POUNDS
HEAVY - LIFTING 50 to 100 POUNDS
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER

LITTLE OR NONE	MODERATE	OFTEN
	✓	
	✓	
✓		
	✓	
	✓	
	✓	
		✓
		✓
		✓
✓		

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

NAVAL SHIPYARD
NORFOLK, VA.

INSTRUCTIONS FOR COMPLETION AND
SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

PART B - PHYSICIAN

EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in item 7)? ☐ YES ☒ NO
Indicate whether Part or Full Time and date able to resume such work

RT TIME ☒ FULL TIME Date (Mo., day, year) *light duty only; in*
hours a day *Consonance with restrictions, in two weeks*

EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS ARE DUE TO THE INJURY. (Including Preexisting Conditions)

WORK TOLERANCE LIMITATIONS

LIFTING 0 to 10 POUNDS

LIFTING 10 to 20 POUNDS

LIFTING 20 to 50 POUNDS

LIFTING 50 to 100 POUNDS

PUSHING, CARRYING

WORKING ABOVE SHOULDER

WORKING (HOURS)

WORKING (HOURS)

WORKING (HOURS)

WORKING (HOURS)

WORKING (HOURS)

WORKING (HOURS)

WORKING (HOURS)

OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.

OTHER LIMITATIONS (Specify).

FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	<input checked="" type="checkbox"/>	
	<input checked="" type="checkbox"/>	
	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
	<input checked="" type="checkbox"/>	

EMPLOYEE IS TOTALLY DISABLED FOR DUTY. GIVE A BRIEF REPORT AND PROGNOSIS

*Out of work for 2 weeks
Light duty after that*

13. DATE OF DISABILITY (If termination date unknown, so indicate) 14. DATE EMPLOYEE ABLE TO RESUME WORK (Mo., day, year)

DISABILITY FROM *Present* TO *22 April*

LIGHT WORK ☒
REGULAR WORK ☐ *in two weeks*

DISABILITY FROM *3 April* TO *Indefinite*

EMPLOYEE IS ABLE TO RESUME WORK. HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED (Mo., day, year)

15. BASIS OF CONDITION DUE TO INJURY

Mr. Ryan has sustained a falling injury to his knee as a result of a fall sustained on the USS AMERICA. The fall resulted torn ligaments and his knee cap was virtually crushed in the fall.

16. DATE OF EXAMINATION 17. DATES OF FURTHER APPOINTMENTS, IF ANY

3/19/83

4/19/83

18. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

James M. Wright

19. PROFESSIONAL DEGREE

M.D.

20. DATE (Mo., day, year)

3/20/83

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

JOB DESCRIPTION
Welder, WG-3703-10

Performs all types of welding on all types of surfaces, such as deck plates, ship's hull, fitting, etc. Is knowledgeable of all welding processes, e.g., MIG, TIG. Is able to perform work with normal supervision.

Assists and instructs helpers and apprentices in the trade.

Incumbent is required to work in all types of environment, and is exposed to heat, noise and cold on board ships and subs. Must be able to weld in any and all types of positions, i.e., kneeling, stooping, bending. May be required to lift up to 30 lbs. Climbs on board ships and subs.

Incumbent will be required to recertify his or her qualifications at two year intervals in the various types of welding processes.

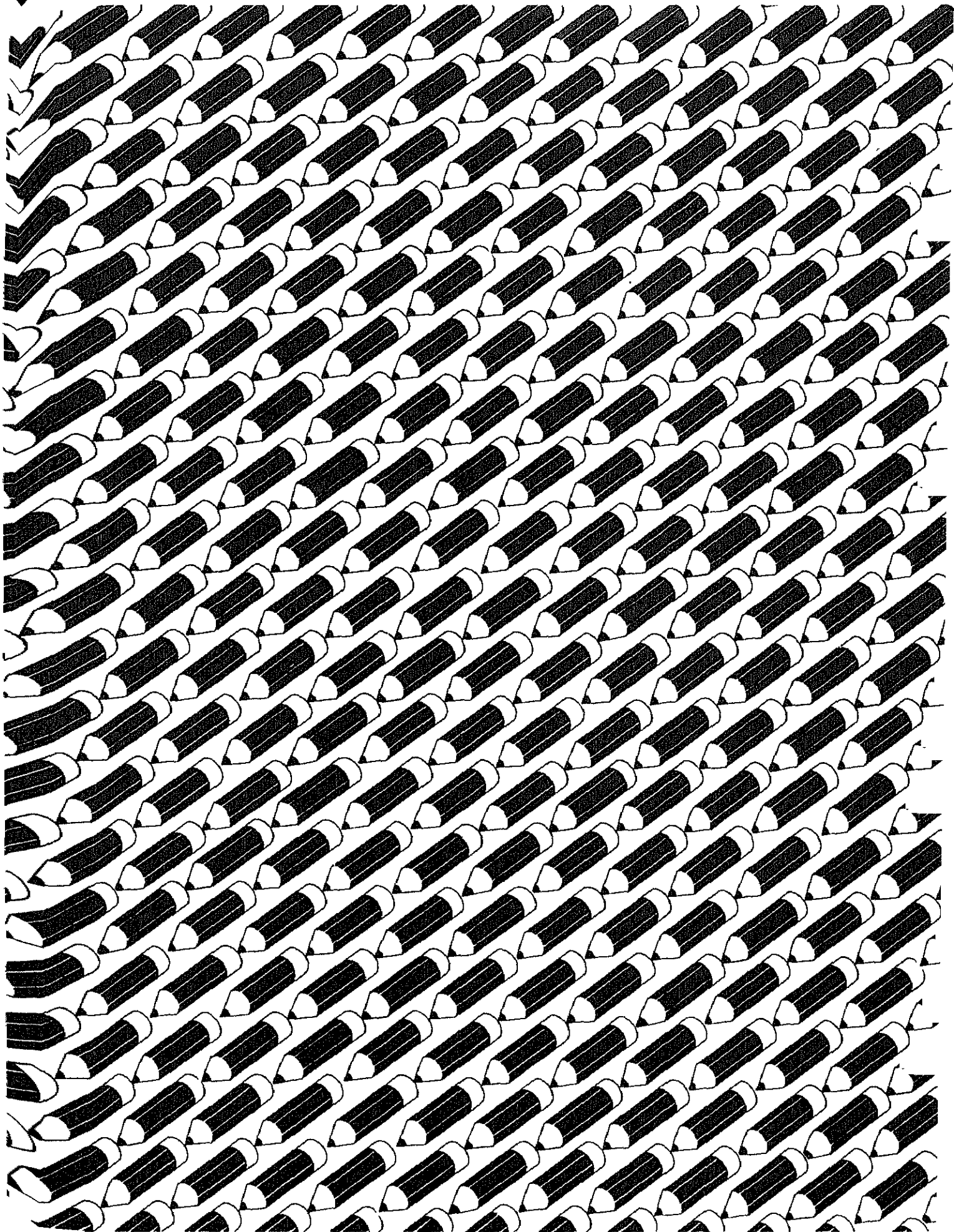
TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

Circle below the letters of those physical job requirements enumerated in the job description on page 151 that conflict with Mr. Ryan's work limitations.

- a) Light lifting - 10 to 20 pounds
- b) Moderate lifting - 20 to 50 pounds
- c) Heavy lifting - 50 to 100 pounds
- d) Pulling, pushing, carrying
- e) Reaching or working above shoulder
- f) Walking
- g) Standing
- h) Sitting
- i) Stooping
- j) Kneeling
- k) Repeated bending
- l) Climbing
- m) Operating a motor vehicle, crane, tractor, etc.

WHEN YOU HAVE COMPLETED THE TASK, TURN TO PAGE 153 AND COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

Answer:

You should have circled the following letters:

- b) Lifting 20 - 50 lbs
- i) Stooping
- j) Kneeling
- k) Repeated bending
- l) Climbing

TURN THE PAGE FOR THE NEXT TASK.

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 2

You solicit a Personal Qualifications Statement, SF-171, from Mr. Ryan. The purpose of this is to obtain current information regarding his experience, education, and training, for possible job placement.

Examine Mr. Ryan's 171 on the following pages. Assume that each description of duties is complete. Focus on the types of jobs he might be qualified for.

After you review the 171 go to the worksheet on page 160 and do the task.

Personal Qualifications Statement

Instructions before completing form

Form Approved
OMB No. 3206-0012

1. Position (job) you are filing for (or title and number of announcement)

2. Positions for which you wish to be considered (if listed in the announcement)

3. Home phone
Area Code Number
031 9217

4. Work phone
Area Code Number Extension
381 17154

5. Other last names ever used

6. Sex
☐ Male ☐ Female

7. Name (Last, First, Middle)
Ryan, James R.

8. Street address or RFD no. (include apartment no. if any)
58 Carpenter St.

9. City
Chesapeake

10. State
Va.

11. ZIP Code
23321

12. Place (City & State) or foreign country
Jacksonville Fla.

13. Date (Month, day, year)
7/18/48

14. Social Security Number
349-80-1763

15. Have you ever been employed by the Federal Government as a civilian, give your highest grade, classification series, and job title
Welder - WG-10

16. Dates of service in highest grade (Month, day and year)
From 8/1978 To Present

17. Do you currently have an application on file with the Office of Personnel Management for appointment to a Federal position, list: (a) the name of the area office maintaining your application, (b) the position for which you filed, and (if appropriate) (c) the date your notice of rating, (d) your identification number and (e) your rating

DO NOT WRITE IN THIS BLOCK FOR USE OF EXAMINING OFFICE ONLY

Material
☐ Submitted ☐ Returned

Entered register

Notations

Form reviewed

Form approved

Option	Grade	Earned Rating	Preference	Aug Rating
			<input type="checkbox"/> 5 Points (Tent)	
			<input type="checkbox"/> 10 Pts 30% or More Comp Dis	
			<input type="checkbox"/> 10 Pts Less Than 30% Comp Dis	
			<input type="checkbox"/> Other 10 Points	
			<input type="checkbox"/> Disallowed	
			<input type="checkbox"/> Being Investigated	

Initials and date

ANNOUNCEMENT NO.
STATEMENT NO.

THIS SPACE FOR USE OF APPOINTING OFFICER ONLY

Preference has been verified through proof that the separation was under honorable conditions, and other proof as required

☐ 5 Point ☐ 10 Points 30% or More Compensable Disability ☐ 10 Points Less Than 30% Compensable Disability ☐ 10 Point Other

Signature and title

Agency Date

18. What pay or grade you will accept

PAY	GRADE
per	WG-10

19. When will you be available for work? (Month and year)
Now

20. Are you available for temporary employment lasting

21. Acceptance or refusal of temporary employment will not affect your consideration for other appointments

22. Are you available for temporary employment lasting

A Less than 1 month?

B 1 to 4 months?

C 5 to 12 months?

23. Are you interested in being considered for employment by

A State and local government agencies?

B Congressional and other public offices?

C Public international organizations?

24. Where will you accept a job?

25. In the Washington, D.C. Metropolitan area?

26. Outside the 50 United States?

27. Anyplace in the United States?

28. Only in (specify locality)

29. Indicate your availability for overnight travel

A Not available for overnight travel

B 1 to 5 nights per month

C 6 to 10 nights per month

D 11 or more nights per month

30. Are you available for part-time positions (fewer than 40 hours per week) offering

A 20 or fewer hours per week?

B 21 to 31 hours per week?

C 32 to 39 hours per week?

31. Veteran Preference Answer all parts. If a part does not apply to you, answer 'NO'

32. Have you ever served on active duty in the United States military service? (Exclude tours of active duty for training in Reserves or National Guard)

33. Have you ever been discharged from the armed services under other than honorable conditions? You may omit any such discharge changed to honorable or general by a Discharge Review Board or similar authority.

34. If "YES", give details in item 34

35. Do you claim 5-point preference based on active duty in the armed forces?

36. If "YES", you will be required to furnish records to support your claim at the time you are appointed

37. Do you claim 10-point preference?

38. If "YES", check the type of preference claimed and complete and attach Standard Form 15, "Claim for 10-Point Veteran Preference," together with the proof requested in that form

39. Type of Preference

☐ Compensable Disability 30% or More

☐ Compensable Disability Below 30%

☐ Non compensable Disability

☐ Purple Heart Recipient

☐ Spouse

☐ Widow(er)

☐ Mother

40. List dates, branch, and serial number of all active service (enter "N/A", if not applicable)

41. From To Branch of Service Serial or Service Number

Apr '70 Apr '74 U.S. NAVY A-196843

FEDERAL GOVERNMENT IS AN EQUAL OPPORTUNITY EMPLOYER

PREVIOUS EDITION USABLE 7540-00-935-7150

171-107

Standard Form 171 (Rev 1/79)
Office of Personnel Management
FPM Chapter 295

21. Experience. Begin with current or most recent job or volunteer experience and work back. Account for periods of unemployment exceeding three months and your residence history at that time on the last line of the experience blocks in order of preference.				
May inquiry be made of your present employer regarding your character, qualifications and record of employment? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
A Name and address of employer's organization (include ZIP code if known) Norfolk Shipyard Norfolk, Va.				
Dates employed (give month and year) From 6/74 To Present		Average number of hours per week 40		
Salary or earnings Beginning \$ 5.60 per hr. Ending \$ 10.50 per hr.		Place of employment City Norfolk State Va		
Exact title of your position Welder		Name of immediate supervisor Roberts		Area Code Telephone number 397 14974
Kind of business or organization (manufacturing, accounting, social services, etc.) Welding		If Federal service, civilian or military, series, grade or rank and date of last promotion WG-10		Number and kind of employees you supervised —
Description of work (Describe your specific duties, responsibilities and accomplishments in this job) Served welder apprenticeship from June of 1974 to June 1978. Have been journeyman welder since 1978.				
For agency use (skill codes, etc.)				
B Name and address of employer's organization (include ZIP code if known) U.S. NAVY				
Dates employed (give month and year) From 4/70 To 4/74		Average number of hours per week 40		
Salary or earnings Beginning \$ per Ending \$ per		Place of employment City Pensacola State Fla		
Exact title of your position Yeoman E-4		Name of immediate supervisor Chief Brooks		Area Code Telephone number 912 397-8492
Kind of business or organization (manufacturing, accounting, social services, etc.) Govt.		If Federal service, civilian or military, series, grade or rank and date of last promotion E-4 1/74		Number and kind of employees you supervised —
Description of work (Describe your specific duties, responsibilities and accomplishments in this job) Worked in the Military Personnel Office at Naval Station, Pensacola. Typed up orders, discharges and fitness reports, sorted mail, answered general inquiries regarding military pay and bonuses. Filed material in appropriate service jackets. See attached.				
For agency use (skill codes, etc.)				
C Name and address of employer's organization (include ZIP code if known) Newport News Shipbuilding & Drydock Newport News Va				
Dates employed (give month and year) From 9/66 To 11/69		Average number of hours per week 40		
Salary or earnings Beginning \$ 2.85 per hr. Ending \$ 4.10 per hr.		Place of employment City Newport News State Va		
Exact title of your position Helper		Name of immediate supervisor Dick Davis		Area Code Telephone number 804 1931-1248
Kind of business or organization (manufacturing, accounting, social services, etc.) Private Shipyard		If Federal service, civilian or military, series, grade or rank and date of last promotion —		Number and kind of employees you supervised —
Description of work (Describe your specific duties, responsibilities and accomplishments in this job) Served as a helper to a welder mechanic.				
For agency use (skill codes, etc.)				

Attach Supplemental Sheets or Forms Here

22 A Special qualifications and skills (skills with machines, patents or inventions, your most important publications (do not submit copies unless requested), your public speaking and publications experience, membership in professional or scientific societies, etc.)

B Kind of license or certificate (pilot, registered nurse, lawyer, radio operator, CPA, etc.)		C Latest license or certificate Year _____ State or other licensing authority _____		D Approximate number of words per minute Typing <u>41 wpm</u> Shorthand _____									
23 A Did you graduate from high school or will you graduate within the next nine months, or do you have a GED high school equivalency certificate?		B Name and location (city and State) of latest high school attended											
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">Yes</td> <td style="width:20%;">Month and Year</td> <td style="width:10%;">No</td> <td style="width:20%;">Highest grade completed</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td><u>6/66</u></td> <td><input type="checkbox"/></td> <td></td> </tr> </table>		Yes	Month and Year	No	Highest grade completed	<input checked="" type="checkbox"/>	<u>6/66</u>	<input type="checkbox"/>		<u>Wilkes High School, Va. Beach, Va.</u>			
Yes	Month and Year	No	Highest grade completed										
<input checked="" type="checkbox"/>	<u>6/66</u>	<input type="checkbox"/>											
C Name and location (city, State, and ZIP Code if known) of college or university (if you expect to graduate within nine months, give MONTH and YEAR you expect to receive your degree)		Dates Attended		No. of Credits Completed									
		From To Day Night		Semester Hours Quarter Hours Type of Degree (e.g. B.A.) Year of Degree									
<u>Tidewater Community College</u>		<u>6/66 9/66</u>		<u>3</u>									
D Chief undergraduate college subjects		No. of Credits Completed		E Chief graduate college subjects									
		Semester Hours Quarter Hours		Semester Hours Quarter Hours									
<u>Data Processing</u>		<u>3</u>											
F Major field of study at highest level of college work													

G Other schools or training (for example, trade, vocational, Armed Forces or business). Give for each the name and location (city, State and ZIP Code if known) of school, dates attended, subjects studied, number of classroom hours of instruction per week, certificate, and any other pertinent data.

1970 - Basic Typing I - 160 classroom hours
1971 - Correspondence Procedures - 40 hours
- Clerical training - 90 classroom hours
Basic Drafting - 40 classroom hours

24 Honors, awards, and fellowships received Honor Graduate, Apprentice School

25 Languages other than English. List the languages (other than English) in which you are proficient and indicate your level of proficiency by putting a check mark (✓) in the appropriate columns. Candidates for positions requiring conversational ability in a language other than English may be given an interview conducted solely in that language. Describe in item 34 how you gained your language skills and the amount of experience you have had (e.g., completed 72 hours of classroom training, spoke language at home for 18 years, self taught, etc.).

Name of Language(s)	PROFICIENCY							
	Can Prepare and Deliver Lectures		Can Converse		Have Facility to Translate Articles, Technical Materials, etc.		Can Read Articles, Technical Materials, etc. for Own Use	
	Fluently	With Difficulty	Fluently	Passably	Into English	From English	Easily	With Difficulty

26 References. List three persons who are NOT related to you and who have definite knowledge of your qualifications and fitness for the position for which you are applying. Do not repeat names of supervisors listed under item 21. Experience.

Full Name	Present Business or Home Address (Number, Street, City, State and ZIP Code)	Telephone Number (include Area Code)	Business or Occupation
<u>Chedwick, Ed. C.</u>	<u>312 Burr Oak, Va. Beach</u>	<u>—</u>	<u>Welder</u>
<u>Martin, Donald</u>	<u>18 Carrier Court, Ches</u>	<u>—</u>	<u>FOREMAN</u>
<u>Edwards, Earl</u>	<u>21 Crestwood Dr. Ches</u>	<u>—</u>	<u>Planner</u>

Continuation Sheet
Item 21B

While in the U. S. Navy from 1970 to 1974, I served as a yeoman in the Military Personnel Office. I was responsible for typing up travel and transfer orders for military personnel.

I filed correspondence in appropriate service jackets and subject matter files. I routed all incoming mail within the office. I prepared memoranda and letters using appropriate naval correspondence procedures.

I typed up fitness reports and discharge notices. I typed most of the correspondence emanating from that office. I was responsible for proper format and punctuation.

I set up a new file system, and a tickler system on all pertinent correspondence and reports. I compiled figures for various reports and checked them for accuracy.

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 2

Assuming that all of the following jobs are in accord with the work limitations, which of the following types of jobs is Mr. Ryan qualified for? Circle the letter in front of your choice(s), then turn to the page listed next to your answer.

- a. Personnel Specialist only. Turn to page 168, Box 3.
- b. Clerk Typist only. Turn to page 167, Box 4.
- c. Drafting (e.g. engineering technician) only. Turn to page 169, Box 3.
- d. File Clerk. Turn to page 161, Box 2.
- e. Both clerk typist and file clerk. Turn to page 170, Box 3.
- f. All positions except drafting. Turn to page 171, Box 1.

1

Yes. He should be assigned to the Personnel Office job (#4) because it has the same starting time (7:30 a.m.) as his regular job.

Now turn to page 144 for the next task.

2

He is qualified for the file clerk position. He has 4 years experience as a yeoman in the Navy and 90 classroom hours of clerical training. However this is not the only job he qualifies for.

Return to page 160 and make another selection.

3

Correct. The best answer is reassign him to the position of Mark-Up Clerk. It best meets Mr. Saunders' new physical limitations.

Now turn to page 148 to begin a new case.

4

Correct. Choice a, Office clerk, is the best match for his work limitations. His physical limitations include no lifting, no reaching above shoulders, and no stooping, kneeling, bending or climbing.

Turn to page 143 to continue the case.

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 3

You have determined that Mr. Ryan would be eligible for clerk-typist and file clerk positions at the GS-4 level. A staffing specialist identifies four series of positions which you have at your facility:

Mail and File Series - 305
Voucher Examining Series - 540
Property Disposal Series - 1107
Clerk-Typist Series - 322

Review the attached Requests for Personnel Action (SF-52's) to determine in which positions Mr. Ryan can be placed.

After reviewing the SF-52's, go on to page 166 to answer the question.

REQUEST FOR PERSONNEL ACTION

PART I. REQUESTING OFFICE: Unless otherwise instructed, fill in all items in this part except those inside the heavy lines. If applicable, obtain resignation and separation data on reverse side.

1 NAME (CAPS) LAST-FIRST-MIDDLE MR--MISS--MRS	2 (For agency use)	3 BIRTH DATE (Mo., Day, Year)	4 SOCIAL SECURITY NO
--	--------------------	----------------------------------	----------------------

A KIND OF ACTION REQUESTED (1) PERSONNEL (Specify appointment, reassignment, resignation, etc.) RECRUIT	B REQUEST NUMBER 839	C DATE OF REQUEST 3/29/83
--	--------------------------------	-------------------------------------

(2) POSITION (Specify establish, review, abolish, etc.)	D PROPOSED EFFECTIVE DATE ASAP	E POSITION SENSITIVITY NS	
5 VETERAN PREFERENCE 1--NO 2--5 PT 3--10 PT DISAB 4--10 PT COMP 5--10 PT OTHER	6 TENURE GROUP	7 SERVICE COMB. DATE	8 HANDICAP CODE
9 FEGLI 1--COVERED (REGULAR ONLY--DECLINED OPTIONAL) 2--INELIGIBLE 3--WAIVED 4--COVERED (REG & OPT)	10 RETIREMENT 1--CS 2--FICA 3--FS 4--NONE 5--OTHER	11 (For CSC use)	
12 NATURE OF ACTION CODE	13 EFFECTIVE DATE (Mo., Day, Year)	14 CIVIL SERVICE OR OTHER LEGAL AUTHORITY	

15 FROM: POSITION TITLE AND NUMBER	16 PAY PLAN AND OCCUPATION CODE	17 (a) GRADE (b) STEP OR LEVEL OR RATE	18. SALARY
19 NAME AND LOCATION OF EMPLOYING OFFICE			

20 TO: POSITION TITLE AND NUMBER Clerk-Typist P.D.#791048 GS-322	21 PAY PLAN AND OCCUPATION CODE GS-322	22 (a) GRADE (b) STEP OR LEVEL OR RATE 04 01	23 SALARY
24 NAME AND LOCATION OF EMPLOYING OFFICE Public Works Dept NAVAL Shipyard (code 407) Norfolk, VA			

25 DUTY STATION (City-county-State) Norfolk, VA	26 LOCATION CODE	
27 APPROPRIATION 00181349	28 POSITION OCCUPIED 1--COMPETITIVE SERVICE 2--EXCEPTED SERVICE	29 APPORTIONED POSITION FROM TO, STATE 1--PROVED-1 2--WAIVED-2

F REMARKS BY REQUESTING OFFICE (Continue in item F on reverse side, if necessary)

G REQUESTED BY (Signature and title) (Leave blank on resignations) Vacancy Created due to resignation of Sarah Fields Anne J. Whitfield		I REQUEST APPROVED BY SIGNATURE Earl Robinson TITLE Head, Data Processing Office
H FOR ADDITIONAL INFORMATION--CALL--(Name and telephone number) X1159		

PART II. TO BE COMPLETED BY PERSONNEL OFFICE (Items inside heavy lines in Part I above also to be completed)

J POSITION CLASSIFICATION ACTION IDENTICAL ADDITIONAL	NEW	VICE	REGRADED
K CLEARANCES	Initials or Signature	Date	(7) REMARKS (Note Use item 30 on reverse for Standard Form 50 remarks) QUALIFICATION STANDARD X118
(1)			
(2) CEIL OR POS CONTROL	js	3/30	
(3) CLASSIFICATION	js	3/30	
(4) PLACEMENT OR EMPL			
(5)			
(6) APPROVED BY			

REQUEST FOR PERSONNEL ACTION

PART I. REQUESTING OFFICE: Unless otherwise instructed, fill in all items in this part except those inside the heavy lines.
If applicable, obtain resignation and separation data on reverse side

1 NAME (CAPS) LAST—FIRST—MIDDLE MR—MISS—MRS.		2 (For agency use)	3 BIRTH DATE (Mo Day, Year)	4 SOCIAL SECURITY NO
A. KIND OF ACTION REQUESTED (1) PERSONNEL (Specify appointment, reassignment, resignation, etc.) RECRUIT		8 REQUEST NUMBER 431		C DATE OF REQUEST 3/28/83
(2) POSITION (Specify establish, review, abolish, etc.)		D PROPOSED EFFECTIVE DATE ASAP		E POSITION SENSITIVITY
5 VETERAN PREFERENCE 1—NO 2—5 PT 3—10 PT DISAB 4—10 PT COMP 5—10 PT OTHER		6 TENURE GROUP		7 SERVICE COMP. DATE
9 FEGLI 1—COVERED (REGULAR ONLY—DECLINED OPTIONAL) 2—INELIGIBLE 3—WAIVED 4—COVERED (REG & OPT)		10 RETIREMENT 1—CS 2—FICA 3—FS 4—NONE 5—OTHER		11 (For CSC use)
12. NATURE OF ACTION CODE		13 EFFECTIVE DATE (Mo, Day, Year)		14 CIVIL SERVICE OR OTHER LEGAL AUTHORITY

15 FROM: POSITION TITLE AND NUMBER	16 PAY PLAN AND OCCUPATION CODE	17 (a) GRADE OR LEVEL (b) STEP OR RATE	18 SALARY
19 NAME AND LOCATION OF EMPLOYING OFFICE			

20 TO: POSITION TITLE AND NUMBER P.D. 684930 SECRETARY (STENO)	21 PAY PLAN AND OCCUPATION CODE GS-318	22 (a) GRADE OR LEVEL (b) STEP OR RATE 05 01	23 SALARY
24 NAME AND LOCATION OF EMPLOYING OFFICE COMPTROLLER DEPT (CODE 390) NAVAL SHIPYARD NORFOLK, VA.			

25 DUTY STATION (City—county—State) NORFOLK, VA.		26 LOCATION CODE	
27 APPROPRIATION 00181349	28 POSITION OCCUPIED 1—COMPETITIVE SERVICE 1 2—EXCEPTED SERVICE	29 APPORTIONED POSITION FROM TO STATE 1—PROVED-1 2—WAIVED-2	

F REMARKS BY REQUESTING OFFICE (Continue in item F on reverse side, if necessary)

G REQUESTED BY (Signature and title) (Leave blank on resignations) James M. Jones, Code 390		I REQUEST APPROVED BY SIGNATURE [Signature] TITLE Asst. Comptroller Dept.	
H FOR ADDITIONAL INFORMATION—CALL (Name and telephone number) X4982			

PART II. TO BE COMPLETED BY PERSONNEL OFFICE (Items inside heavy lines in Part I above also to be completed)

J POSITION CLASSIFICATION ACTION IDENTICAL ADDITIONAL		NEW		VICE		REGRADED	
K CLEARANCES	Initials or Signature	Date	(7) REMARKS (Note: Use item 30 on reverse for Standard Form 50 remarks)				
(1)			QUALIFICATION STANDARD X118				
(2) CEIL OR POS CONTROL	elm	3/29/83					
(3) CLASSIFICATION	00	4/1/83					
(4) PLACEMENT OR EMPL.							
(5)							
(6) APPROVED BY							

REQUEST FOR PERSONNEL ACTION

PART I. REQUESTING OFFICE: Unless otherwise instructed, fill in all items in this part except those inside the heavy lines. If applicable, obtain resignation and separation data on reverse side.

1 NAME (CAPS) LAST-FIRST-MIDDLE MR -MISS-MRS.		2 (For agency use)	3 BIRTH DATE (Mo., Day, Year)	4 SOCIAL SECURITY NO
A KIND OF ACTION REQUESTED (1) PERSONNEL (Specify appointment, reassignment, resignation, etc.) Recruit		B REQUEST NUMBER 854		C DATE OF REQUEST 3/31/84
(2) POSITION (Specify establish, review, abolish, etc.)		D. PROPOSED EFFECTIVE DATE ASAP		E. POSITION SENSITIVITY
5 VETERAN PREFERENCE 1—NO 2—5 PT 3—10 PT. DISAB 4—10 PT COMP 5—10 PT. OTHER		6 TENURE GROUP		7 SERVICE COMP. DATE
9. FEGLI 1—COVERED (REGULAR ONLY—DECLINED OPTIONAL) 2—INELIGIBLE 3—WAIVED 4—COVERED (REG & OPT)		10 RETIREMENT 1—CS 2—FICA 3—FS 4—NONE 5—OTHER		11 (For CSC use)
12. NATURE OF ACTION CODE		13 EFFECTIVE DATE (Mo., Day, Year)		14. CIVIL SERVICE OR OTHER LEGAL AUTHORITY

15 FROM: POSITION TITLE AND NUMBER	16. PAY PLAN AND OCCUPATION CODE	17 (a) GRADE (b) STEP OR LEVEL	18. SALARY
19 NAME AND LOCATION OF EMPLOYING OFFICE			

20. TO: POSITION TITLE AND NUMBER MAIL: File Clerk P.D.#87491	21. PAY PLAN AND OCCUPATION CODE G5-305	22. (a) GRADE (b) STEP OR LEVEL 014 01	23. SALARY
24. NAME AND LOCATION OF EMPLOYING OFFICE Administrative Dept. (Code 390) NAVAL SHIPYARD Norfolk, Va.			

25 DUTY STATION (City-county-State) Norfolk, Va	26. LOCATION CODE	
27. APPROPRIATION 00181349	28. POSITION OCCUPIED 1—COMPETITIVE SERVICE 2—EXCEPTED SERVICE	29. APPORTIONED POSITION FROM: 1—PROVED-1 2—WAIVED-2 TO: STATE

F. REMARKS BY REQUESTING OFFICE (Continue in item F on reverse side, if necessary)

G. REQUESTED BY (Signature and title) (Leave blank on resignations) New position Jane Woodshire, Admin Dept		I. REQUEST APPROVED BY: SIGNATURE J. H. Cooper TITLE: CAPT. USN	
H. FOR ADDITIONAL INFORMATION—CALL (Name and telephone number) X7201			

PART II. TO BE COMPLETED BY PERSONNEL OFFICE (Items inside heavy lines in Part I above also to be completed)

J POSITION CLASSIFICATION ACTION IDENTICAL ADDITIONAL		NEW		VICE		REGRADED	
K CLEARANCES	Initials or Signature	Date	(7) REMARKS. (Note: Use item 30 on reverse for Standard Form 50 remarks) X118				
(1)			QUALIFICATION STANDARD:				
(2) CEIL. OR POS CONTROL							
(3) CLASSIFICATION							
(4) PLACEMENT OR EMPL.							
(5)							
(6) APPROVED BY:							

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 3

Circle the letter below in front of the positions for which Mr. Ryan can qualify:

- a. Clerk Typist. Turn to page 168, Box 1.
- b. Secretary (steno). Turn to page 167, Box 3.
- c. Mail and File Clerk. Turn to page 169, Box 2.
- d. Both the clerk typist and mail and file clerk. Turn to page 171, Box 2.
- e. All three positions (a - c). Turn to page 170, Box 1.

1

No. The physical requirements for the position of Office Clerk are now far below his capabilities.

Return to page 147 for another try.

2

No, not the closest to his regular working conditions.

Return to page 143 for another try.

3

No. He does not have sufficient stenographic skills for this position.

Return to page 166 and try again.

4

Correct. Clerk typist - 4 years experience as a yeoman in the Navy and 160 classroom hours of typing. He also types 41 words per minute. However, this is not the only job he qualifies for.

Return to page 160 and make another selection.

1

Yes. He qualifies as a clerk typist, but not only for this job.

Return to page 166 and try again.

2

No. The lifting and standing requirements for the position of File Clerk are beyond his capabilities.

Return to page 147 for another try.

3

No. Personnel specialist - although he worked in personnel office his duties were essentially clerical.

Return to page 160 and try again.

4

No. This is not the best choice. What conditions of this job are different from his regular job.

Return to page 143 for another selection.

1

No. This isn't the closest to the conditions of his regular job.

Return to page 143 for another try.

2

Yes he does qualify for this job, but not this job alone.

Return to page 166 for another try.

3

No. Drafting - 40 hours of basic classroom training. This would be insufficient to qualify him for a technician position.

Return to page 160 and try again.

4

Not correct. Return to page 78 and make another selection.

1

No. He does not qualify for all three.
Return to page 166 to pick another answer.

2

Not really. Although there may be witnesses, the best source of finding them would be through the claimant.
Return to page 20 for another try.

3

Correct. He is qualified for the clerk typist position. He has 4 years experience as a yeoman in the Navy and 160 classroom hours of typing. He also types 41 words per minute.

and
He qualifies for the file clerk position because of his 4 years experience as a yeoman in the Navy, plus 90 classroom hours of clerical training.

Now turn to page 162 for the next task in this case.

4

1

Not quite. It is true that he does not qualify in drafting. He has only 40 hours of basic classroom training. This would be insufficient to qualify him for a technician position. However, he does not qualify for all three of the other jobs.

Return to page 160 and try again.

2

Correct. Mr. Ryan can qualify for the Mail and File Clerk and Clerk-Typist positions. These are the types of positions he held previously and they are GS-4 positions.

This is the end of this module. Turn to page 172 to begin a new module.

3

4

TASK BOOK
REVIEW OF CHARGEBACK LIST
CASE 1

Read the Resource Book, pages 48 - 53.

- a. Read the chart below which duplicates the chart on page 52 of the Resource Book. If the dollar figures seem very unrealistic for your area, cross them out on the chart below and insert the dollar figures you would use.

INDICATORS FOR POSSIBLE PAYMENT ERRORS

If:	Higher than normal compensation payments
Then:	Verify that payments are correct
If:	Very high medical costs (\$10,000 or more)
Then:	Check medical costs for duplicate payments or billing errors.
If:	High medical costs (over \$1,000) and no compensation
Then:	Check for duplicate payments or billing errors.

- b. Review the chargeback billing list on the following page. Identify cases for possible payment errors only. Use the rules in the chart above for this task. List below the claimants whose payments may be in error and your reason for selecting them. The average full compensation range for this agency is \$12,000 to \$20,000. Refer to the chart on page 52 of the Resource if you need to. As you work with the pages of chargeback lists, you might want to use a ruler or a straight edge.

NOTE: On the chargeback lists used for these cases, to save space the last 2 columns for the total number and amount of payments have been deleted.

AFTER YOU HAVE WRITTEN YOUR ANSWERS, TURN TO PAGE 174 TO COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

b71PCB40

REPORT DATE: 07/31/83 DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1, 1982-JUNE 30, 1983

DEPARTMENT: TENNESSEE VALLEY AUTHORITY

E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS

AGENCY: POWER

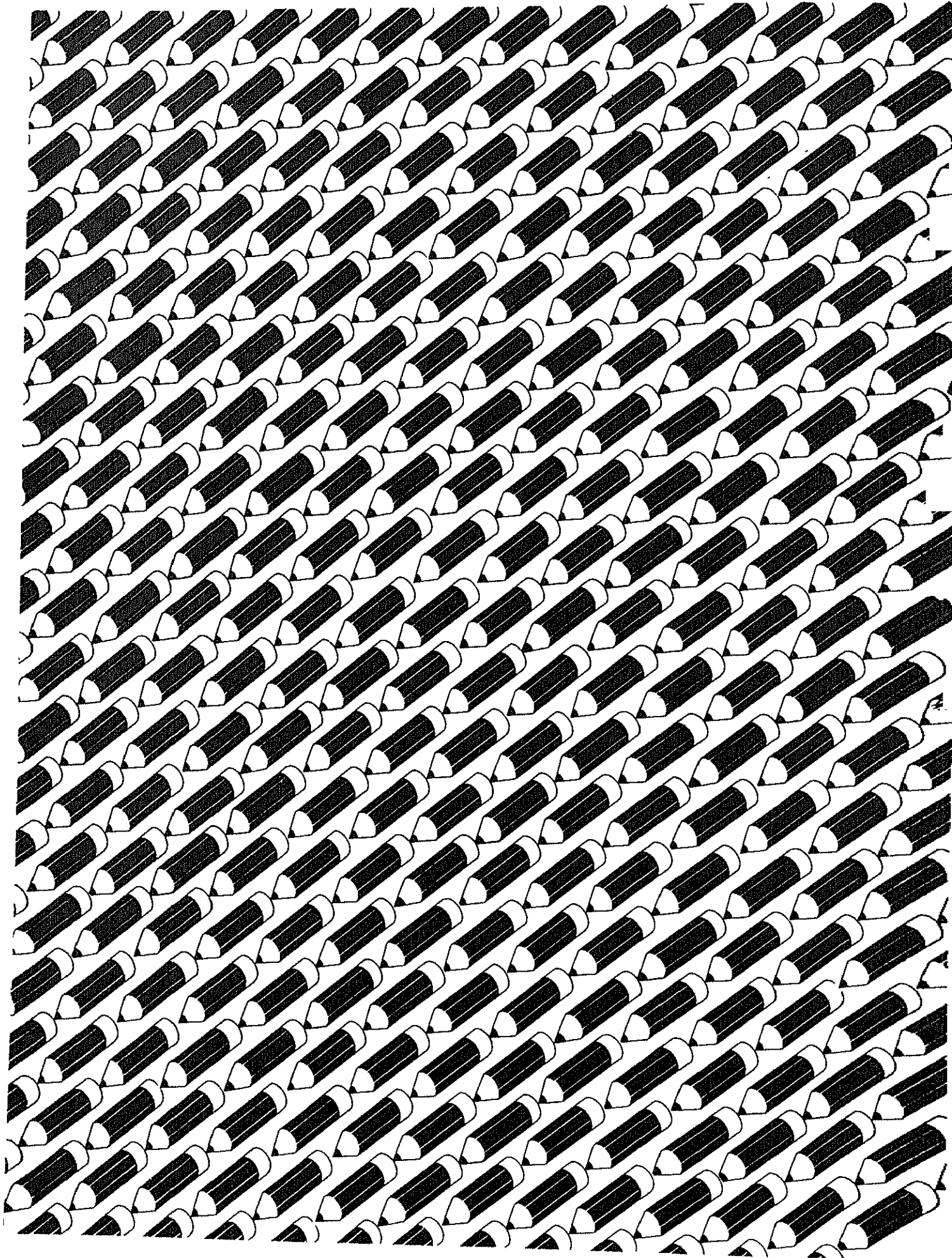
ACCOUNT: DIVISION OF POWER PRODUCTION

ACCOUNT NUMBER: 1550

PD	EMPLOYEE NAME	DATE OF INJURY	MEDICAL		PAYMENTS		A
			NO.	AMOUNT	NO.	AMOUNT	
17	FELTY	12/04/78			15	6,336.05	D
17	BROWN	11/18/78	2	44.00	14	12,367.50	P
06	CROW	12/18/78	3	435.00	14	6,403.60	P
06	BURKS	01/05/79	2	145.00	14	14,373.32	P
06	LAWSON	12/03/78	1	260.00	14	8,692.35	P
06	LEE	02/01/79	1		1	3,035.48	S
06	ROBINETT	02/02/79	1	13.50			
17	COLE	03/06/79			14	11,476.13	P
06	DOVER	02/23/79	8	382.65	14	33,372.32	P
06	LEE	10/26/78	10	598.00	14	49,317.70	P
17	SLAVEN	12/07/78	6	199.00	14	2,236.75	P
06	BARLOW	03/06/78	11	1,806.42			
17	* BIERKAMP	01/04/79	1	30.00			
06	BRAUN	02/14/79	2	365.60	4	5,035.26	S
06	HOFFMAN	02/17/79	5	345.84	15	19,225.61	P
06	RALPH	03/19/79			5	6,192.68	S
06	BARTON	04/09/79	21	3,692.71	14	16,071.26	P
06	EDER	04/05/79	9	603.00	14	4,824.50	P
06	CAMPBELL	04/18/79			1	431.20	S
06	HOLLIFIELD	03/14/79	5	2,393.45			
17	GILBERT	04/02/79	1	16.00	14	14,962.14	P
06	GUNNING	05/08/79	13	220.34	14	19,604.64	P
06	PENTECOST	05/20/79	4	27.80	11	4,778.04	P
06	ADCOCK	05/11/79	9	908.90	14	15,449.28	P
06	BIVENS	05/29/79	31	970.43	14	19,959.46	P
06	MORRIS	07/18/79	33	7,499.54	11	18,954.05	P
06	GASTON	07/15/79	5	359.25	1	2,778.05	S
06	MCMILLAN	07/03/79			1	1,121.05	S
17	JOHNSON	08/06/79	3	347.00	14	12,478.39	P
06	FULLER	08/24/79	2	125.21			
17	DAVIS	12/01/79	38	28,866.89	14	10,902.10	P
17	FERGERSON	11/18/79	24	887.44	14	6,991.28	P

CASE MATERIAL

ENDS HERE



Answer:

The following are cases you would check for possible billing errors:

1. Albert Dover - High compensation amount of \$33,372.32 appears higher than the normal compensation range for this agency.
2. Lester Lee - There was an extremely high amount of compensation paid to Mr. Lee - \$49,317.70. This is above the compensation range for this agency.
3. James Barlow - Medical costs are over \$1,000 and there are no compensation payments.
4. John Hollifield - There were high medical costs incurred (\$2393.45) and no compensation payments.
5. Bernard Davis - Very high medical costs (\$28,866.89).

You might be tempted to pick the following people, but would not for the reasons stated:

L. Barton. Although the medical payments are over \$1,000, the rule says "high medical over \$1,000 and no compensation". He received 14 compensation payments so you would not list him.

Ben Morris. Although his medical costs are high, they are not up to the \$10,000 cut-off point and he does not meet the "over \$1,000 and no compensation" rule.

TURN THE PAGE.

TASK BOOK
REVIEW OF CHARGEBACK LIST

In the next three segments, you will be moving back and forth between two different kinds of work.

First you will review part of an agency's annual chargeback list to identify cases that will need to be reviewed. Then you work with an actual file on one of the cases you have identified and make some decisions about it.

This cycle will be repeated.

TURN THE PAGE TO BEGIN THE NEXT TASK.

CASE 2
TASK 1

Read the Resource Book, pages 54 ~ 56. This section deals with reviewing cases for continuing disability.

Review the following page from the Chargeback Billing List. For this task, assume that today's date is April 1, 1984. Also assume that normal full compensation range for this agency is \$10,500 to \$20,000.

- a. List those priority cases to review for continuing disability. (For this task do not list cases for possible overpayments.) If you want to consult the Resource, refer to the chart on page 56.
- b. Give your rationale for your selections. Write your answers below.

NOW COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS ON PAGE 178.

bV1PCB40

REPORT DATE: 07/31/83 DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1, 1982-JUNE 30, 1983

E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS

DEPARTMENT: TENNESSEE VALLEY AUTHORITY

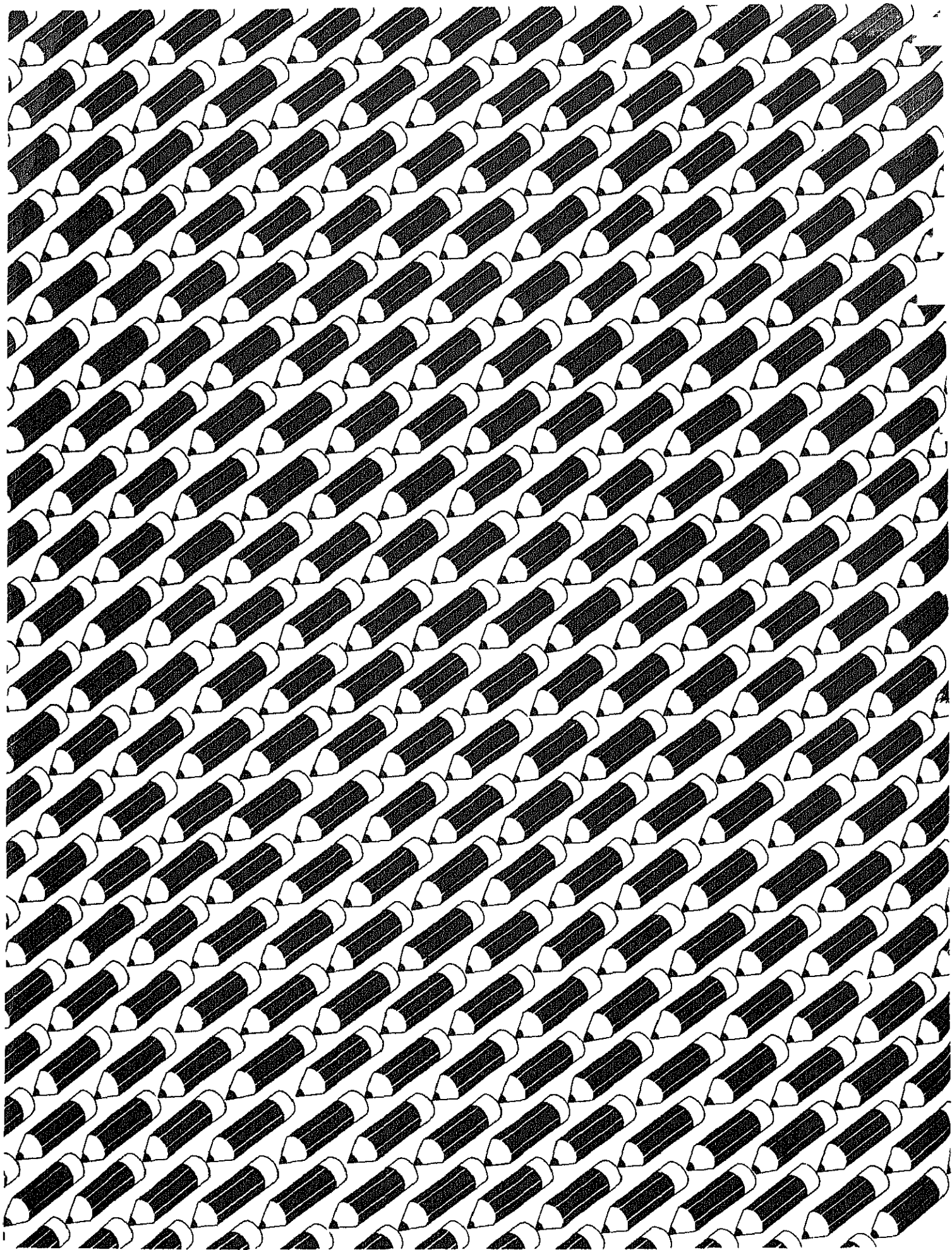
AGENCY: POWER

ACCOUNT: DIVISION OF POWER PRODUCTION

ACCOUNT NUMBER: 1550

PD	EMPLOYEE NAME	DATE OF INJURY	NO.	MEDICAL AMOUNT	NO.	COMPENSATION AMOUNT	PAYMENTS	A
06	PENLAND	04/29/79	4	154.00	4	5,989.35	P	
06	NEWCOMB	02/22/80	10	699.75	14	17,899.96	S	
06	JACKSON	03/20/80			3	2,472.20	S	
06	HUTCHISON	03/04/80	1	18.00				
06	HITCHCOX	02/07/80	1	196.00				
17	HAM	04/16/80						
06	CHAMBERS	02/15/80	1	40.00	2	14,485.30	D	
06	BLEDSOE	03/06/80	7	226.00				
06	RILEY	03/21/80	8	237.01	12	14,980.01	P	
06	COOK	04/03/80	3	147.80	4	5,903.88	S	
06	TEMPLETON	03/08/80	11	4,556.13	14	18,445.53	S	
06	SMITH	03/06/80	5	1,055.17	4	4,909.65	P	
06	MAYFIELD	03/17/80	3	64.12	1	1,342.20	S	
06	DUBOIS	04/22/82	19	2,655.42				
06	ATCHLEY	04/16/80	1	22.00	14	16,727.07	P	
06	MANSELL	05/05/80	32	9,227.22	12	17,541.58	S	
06	JACKSON	05/08/82	18	2,087.04	14	18,726.00	D	
17	LATHAM	08/07/80	12	261.75	5	939.54	S	
06	COOPER	12/18/79	1	10.00				
06	ODOM	06/24/82	3	75.00				
06	MITCHELL	08/12/82						
06	FAUTT	11/05/79						
06	WHITMORE	02/03/83	27	3,285.25	1	1,546.80	S	
17	HALL	03/01/62			14	11,595.92	P	
17	TAYLOR	03/20/81	1	40.00	14	11,439.92	P	
17	NEWSOME	04/11/62			14	19,262.82	P	
17	CUMMINS	03/29/62	3	272.95	14	17,159.89	P	
17	THORNTON	04/18/62			14	935.28	P	
17	STANDRIDGE	06/01/62	2	92.00	14	15,362.82	P	
17	CROWE	06/08/62			5	727.30	S	

TASK MATERIAL
ENDS HERE



Answer:

The following cases need to be reviewed on medical grounds:

1. Bailey Templeton has received four compensation payments, but has very high medical costs \$4,556.13 and a date of injury older than two years (3-08-80).
2. Richard Mansell has received 14 compensation payments and very high medical payments (32 of them for a total of \$9,227.22) and his date of injury is prior to April 1, 1982.
3. Freddie Hall is on the periodic roll (received 14 payments) yet had no medical costs.
4. Aaron Taylor is receiving full compensation and had low medical payments (only \$40.00 which would be one or two office visits.
5. William J Newsome - Although he is on the periodic roll for being totally disabled, he is incurring no medical costs.
6. James Standridge is on the periodic roll (determined from 14 payments), but has low medical payments (less than \$92.00).

You would not select Michael Dubois, Roe Jackson, or Marvin Whitmore whose medical payments are over \$2,000 - their dates of injury are not prior to April 1, 1982.

You would not pick Ronald Latham's case with full compensation and no medical because it is a death case.

You would not pick Judith Jackson or James Crowe because they do not have 14 or more compensation payments.

You would not select Danny Newcomb or Phil Cook because they do not have over 14 compensation payments - they have just 14 which is normal.

You would not choose Carl Thornton's case with no medical payments because the low compensation rate of \$935.28 indicates he is probably LWEC.

TURN THE PAGE AND DO THE NEXT TASK.

TAYLOR CASE
TASK 1

Read the Resource Book, pages 58 - 63 on Long Term Case Review.

You get the case of Aaron Taylor to review. You find that he is receiving total disability compensation for back sprain incurred on 3/20/81. The \$40.00 medical expense was for an office visit to his physician on 6/6/82. (See Dr. Steward's report of that exam on the following page.)

The file also contains a medical report dated 8/12/82 and an OWCP 5 (Work Restriction Evaluation) dated 9/30/82.

No other more recent medical evidence is in the file.

Examine these documents on the following three pages, then go to page 183 to answer the question.

TASK BOOK
REVIEW OF CHARGEBACK LIST
TAYLOR CASE
TASK 1

STANLEY L. STEWARD, M.D.
812 Market Street
Greenville, Kentucky

Re: Aaron Taylor

June 6, 1982

To Whom It May Concern:

Mr. Taylor returns today stating his back is no better. He states the walking and exercise program I recommended has been of no benefit. Mr. Taylor feels he is unable to work.

Impression: Lumbar disc syndrome

S. L. Steward, M.D.

STANLEY L. STEWARD, M.D.
812 Market Street
Greenville, Kentucky

Re: Aaron Taylor 085

August 12, 1982

Office of Workers' Compensation Programs:
Jacksonville, Florida

This is to respond to your request for my findings during the June 6 evaluation of Mr. Taylor.

Mr. Taylor reported he was always in pain and felt he would never be able to return to work. X-rays were within normal limits as was his range of motion. Any pressure I applied to the lumbar area caused Mr. Taylor pain from tenderness.

Mr. Taylor's continuous pain and lack of desire to work leads me to feel he would be a poor candidate to return to any type of gainful employment.

S. L. Steward, M.D.

WORK RESTRICTION EVALUATION

Injured workers' name (First, middle, last)

Warren Taylor

2nd OWCP No.

A7-085

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY									
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8	
a. Sitting				✓								
b. Walking			✓									
c. Lifting			✓									
d. Bending			✓									
e. Squatting			✓									
f. Climbing			✓									
g. Kneeling			✓									
h. Twisting			✓									
i. Standing			✓									

4. Check the lifting restriction.

☒ 0-10 lbs. ☐ 10-20 lbs. ☐ 20-50 lbs. ☐ 50-75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?

☐ No ☐ Yes - (Check b, c, and d.)

5b. Simple grasping?

☒ Yes ☐ No

5c. Pushing and pulling?

☒ Yes ☐ No

5d. Fine manipulation?

☐ Yes ☒ No

6. Can the worker reach or work above the shoulder?

☐ Yes ☒ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement?

☐ Yes ☒ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle?

☐ Yes ☒ No

9. Are there cardiac, visual, or hearing limitations?

☐ No ☒ Yes - (Describe) *being treated for this condition per clmt*

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases?

☐ No ☒ Yes - (Describe) *clmt must guard against cold weather (back pain)*

11. Are interpersonal relations affected because of a neuropsychiatric condition?

☐ No ☐ Yes - Describe (Ability to give and take supervision, meet deadlines, etc.)

12a. Can the individual work eight hours a day?

☐ Yes ☒ No - (Indicate when)

12b. If not eight hours, how many and when?

none

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work?

☐ Yes ☒ No *has had rehab*

14. Has the worker reached maximum improvement?

☒ Yes (Indicate when) *6 mos after surgery* ☐ No (Indicate when)

15. Remarks: (Restrictions from medication or other limitations)

16. Name *S. L. Steward*

17. Signature

18. Address *812 Market Street, Greenville, Kentucky*

19. Telephone No.

889-4732

20. Date

9/30/82

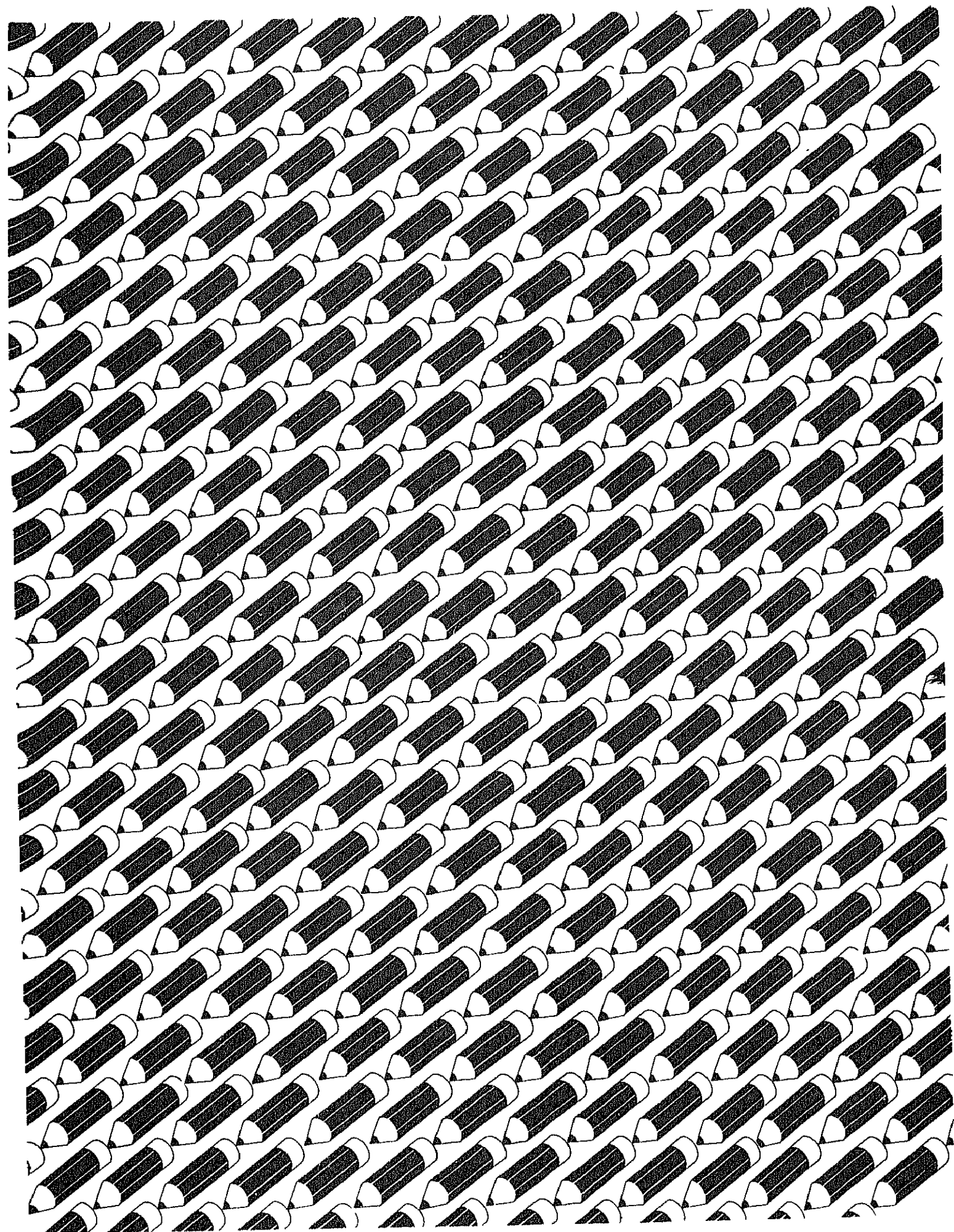
TASK BOOK
REVIEW OF CHARGEBACK LIST
TAYLOR CASE
TASK 1

- a. Is the medical evidence for Aaron Taylor sufficient to justify continuing disability for work?
- b. 1) If yes, why is it?
2) If no, what specifically is missing?

WRITE YOUR ANSWERS BELOW.

AFTER YOU HAVE WRITTEN YOUR ANSWERS TURN TO PAGE 184 TO COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

TASK MATERIAL ENDS HERE



TASK BOOK
REVIEW OF CHARGEBACK LIST
TAYLOR CASE
TASK 1

Answer:

- a. The medical evidence is not sufficient to justify continuing disability for work.
- b. The following is missing:
 - 1. There are no objective findings noted. Dr. Steward indicated Mr. Taylor's inability to work was based on his subjective complaints of pain.
 - 2. There, evidently, has been no medical evidence submitted to support disability after August 12, 1982.

GO ON TO THE NEXT CASE.

Refer to the Resource Book, pages 50 - 57, especially the chart on page 57.

Review the following page from a chargeback billing list. For this task, assume today's date is November 28, 1983. Also assume that normal full compensation range for this agency is \$10,000 to \$23,000.

- a. List those cases where there may be payment errors.
- b. List those priority cases to review for continuing disability.

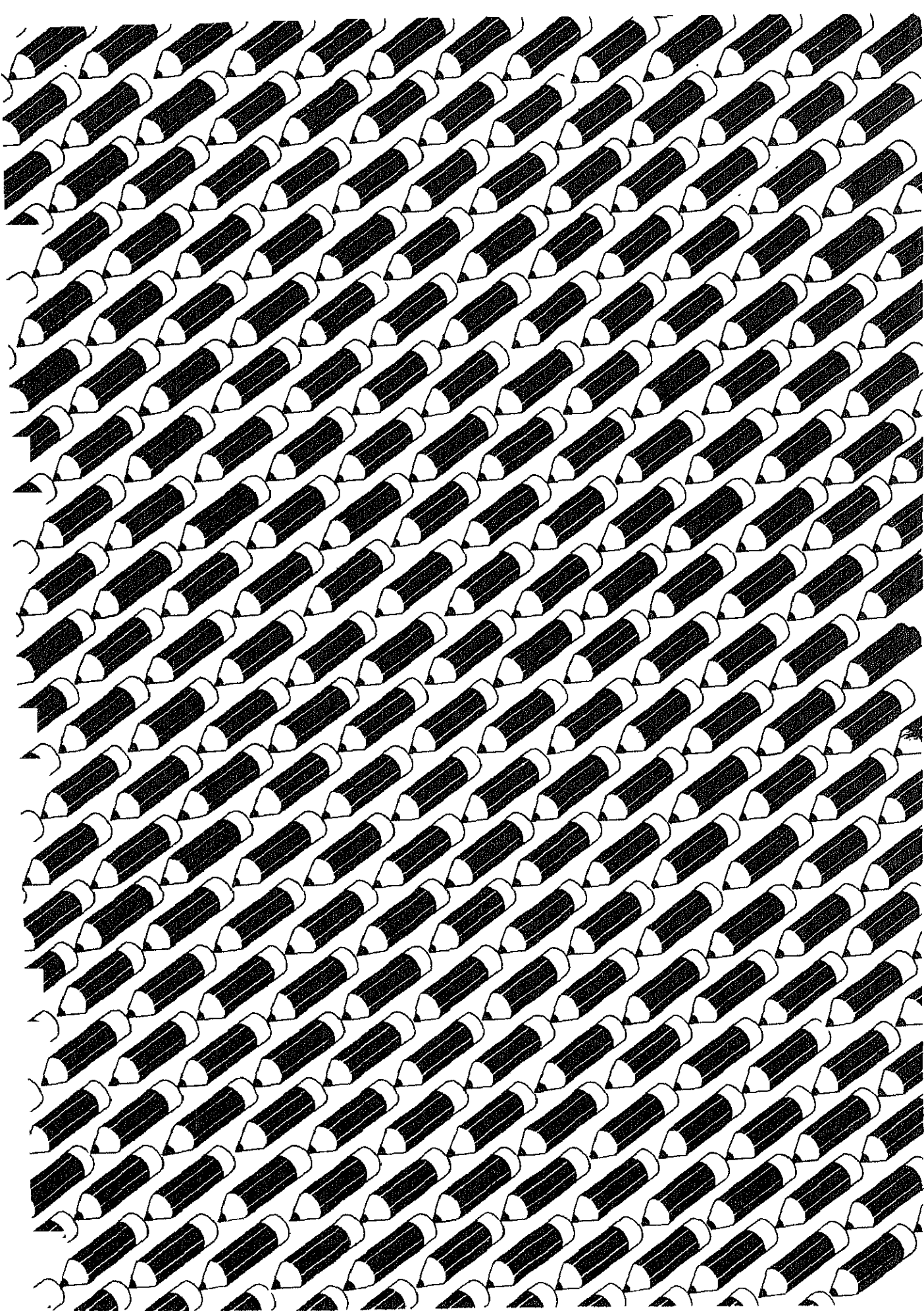
Give your rationale for each selection. Write your answers below. The chart on page 57 of the Resource material may be helpful for this task.

AFTER YOU HAVE WRITTEN YOUR ANSWERS GO TO PAGE 187 TO COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

REPORT DATE: 07/31/83 DETAILED CHARGEDBACK BILLING LIST FOR PERIOD: JULY 1, 1982-JUNE 30, 1983
 DEPARTMENT: TENNESSEE VALLEY AUTHORITY
 ACCOUNT: DIVISION OF FOSSIL AND HYDRO POWER
 E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS
 AGENCY: POWER
 ACCOUNT NUMBER: 1553

PD	EMPLOYEE NAME	DATE OF INJURY	NO.	MEDICAL AMOUNT	NO.	COMPENSATION AMOUNT	ROLL	A
06	EVANS	01/13/81	16	1,296.08				
06	HICKS	12/27/80	29	4,236.88	14	18,436.17	P	
06	ROBERTS	01/01/81	1	69.50				
06	LOUDY	08/15/80						
06	* FORTNER	12/09/80	2	537.00	14	18,726.00	P	
06	BREECE	01/19/81						
06	CROUCH	03/09/81						
06	ARMS	03/19/81	22	17,209.69	14	22,131.21	P	
06	GREEN	03/20/81	1	30.00	14	20,353.28	P	
06	MCMURTRY	03/04/81	1	798.95				
06	HORNER	02/19/81	2	50.00				
06	HOLAWAY	02/25/81	4	327.27				
06	BERUBE	02/26/81	1	9.20	2	2,496.51	P	
06	THARP	04/03/81	1	8.00				
06	MCGOWAN	02/04/81	1	18.00				
06	RUST	04/01/81	2	105.75				
06	LONG	04/07/81	3	66.58				
06	* BATSON	03/10/81	24	12,141.66	14	14,198.22	S	*
06	GOLDSBY	04/22/81			2	2,258.50	S	*
06	MORGAN	04/09/81	1	38.50				
06	MILLAY	04/16/81	3	1,543.90				
06	PRESSON	04/23/81	3	215.50	16	19,439.31	S	
06	GIBSON	05/06/81	2	32.00	3	2,472.54	P	
06	BELL	05/14/81	1	65.00				
06	HEMSLEY	04/30/81	3	225.60	4	7,370.72	S	*
06	COLLINS	12/18/82	1	18.00	4	593.64	P	
06	HUDDLESTON	10/29/80	29	4,285.09	14	20,353.28	P	
			1	92.00	14	20,353.28	P	

END OF CASE MATERIAL



TASK BOOK
REVIEW OF CHARGEBACK LIST
CASE 3
TASK 1

Answer:

- a. The following cases should be reviewed for possible payment errors:

Robert Evans. His medical costs are over \$1,000 and there are no compensation costs.

Jimmy Crouch. Medical payments are very high (over \$10,000) - \$17,209.69.

Thomas Long. Medical payments are over \$10,000.

Michael Morgan. High medical costs and no compensation costs.

- b. The following cases should be reviewed for continuing disability:

Kennith Hicks. His medical costs are high (over \$2,000) and his date of injury is over 2 years old.

Richard Loudy. He is receiving full compensation and has no medical costs.

Charles Breece. He is receiving full compensation and has no medical costs.

Jimmy Crouch. He is receiving full compensation, has high medical costs, and his date of injury is over 2 years old.

Thomas Long. High medical costs of \$12,141.66 and date of injury is over 2 years old.

Chester Huddleston. He is receiving full compensation and has only \$92.00 in medical costs.

You notice that Jude Batson has no medical costs and the date of injury is over 2 years old. But you would not select him because he did not receive full compensation (14 payments).

Although his medical costs are high (\$4,285.09), you would not select Lee Collins because his date of injury is not older than November 28, 1982

GO ON TO THE NEXT TASK.

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE
TASK 1

In reviewing the latest chargeback list you identified several cases for review. One of these is the case of Virginia Williams. You pull the file and find that Ms. Williams's case was accepted for back strain due to a 1980 injury. She was separated from the agency on 6-1-81. Assume today's date to be Dec. 4, 1983.

If you need to refer to the Resource Book, the reference material can be found on pages 58 - 62.

Review the most recent medical report on the following page and answer question below:

Does the medical evidence adequately support continuing disability?

a. Yes. Turn to page 211, Box 3.

b. No. Turn to page 212, Box 1.

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE
TASK 1

MEDICAL REPORT

PATIENT: Virginia Williams
Date: 3/14/81

Patient was seen by me this date complaining of continuing back pain. As I have diagnosed earlier, Ms. Williams is suffering from degenerative arthritis of the spine, as well as from diabetes.

Blood test results show continued high sugar level. I prescribed daily injections of insulin, to be continued indefinitely. I emphasized the need to continue with her controlled diet.

Bending and stooping caused patient considerable pain. In fact, patient complains that she is in pain most of the time.

I advised patient to apply moist heat to the back, and prescribed FIORINAL for pain.

Patient continues to be disabled for work.

J. H. Rider, M.D.
Internal Medicine
3/14/81

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE
TASK 2

The medical report on page 189 is adequate in which of the following areas? Circle the letter of your answer, then turn to the referenced page.

- a. It contains objective findings. Turn to page 253, Box 4.
- b. The medical evidence is current. Turn to page 273, Box 3.
- c. There is adequate support for total disability. Turn to page 212, Box 2.
- d. The disability is linked to a job injury. Turn to page 252, Box 1.
- e. None of the above. Turn to page 252, Box 3.

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE
TASK 3

What action would you take next?

- a. Order a Fitness for Duty medical exam. Turn to page 253, Box 2.
- b. Request OWCP to get an updated medical report addressing the inadequacies of the 3-14-81 report. Turn to page 211, Box 2.
- c. Write to Dr. Rider asking him to provide the missing information. Turn to page 252, Box 1.
- d. Order Ms. Williams to report to work. Turn to page 212, Box 4.

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE

EXAMPLE

District Director
OWCP
3010 11th Street, N.W.
Washington, D.C. 30510

Re: Williams, Virginia, Claim #024376

Dear Sirs:

I am writing in regard to the above named claimant who is being paid compensation by your office. Ms. Williams sustained a severe muscle strain to her back in 1980.

The most recent medical report in our files shows that on the date of the most recent examination, 3/14/81, Ms. Williams was suffering from osteoarthritis, i.e., degenerative arthritis of the spine, and diabetes.

In view of the lack of current medical evidence specifically showing how her disability relates to the residuals of her 1980 injury, please have her submit new medical evidence.

We request that the results of this examination be carefully reviewed to determine if her current disability is in any way related to the 1980 injury. If not, we request cessation of medical benefits. Please advise.

Sincerely,

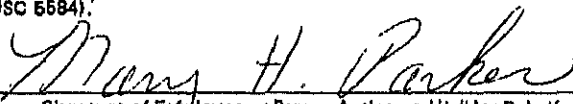

Edith Rogers,
Head, Compensation Branch

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

Review the Resource pages 58 - 63 if you need to.

In reviewing the current chargeback billing list you identified the case of Mary Parker to review on medical grounds. The claimant has been taken off the agency's rolls. You are now going to review her case file. Assume today's date is August 15, 1984.

Review the following file documents (pages 194 - 209). Then answer the question on page 210.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Parker, Mary H.		2. Date of Birth 5/1/54	3. <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
		4. Social Security Number 218-04-1926	
5. Employee's Home Mailing Address (No. street, city, state, zip code) 606 Meadow View Rd Portsmouth, Va 23709		6. Home Telephone Area Code: 804 Number: 488-2121	
7. Name and Address of Employing Agency Norfolk Naval Shipyard Industrial Relations Office Portsmouth, Va 23709		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) Supply Room Bldg 264	
9. Date and Hour of Injury (mo., day, year) 4/30/78 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	10. Date of This Notice (mo., day, year) 5/1/78	11. Dependents Wife/Husband <input checked="" type="checkbox"/> Children Under 18 Years Old <input checked="" type="checkbox"/>	12. Employee's Occupation clerk: typist
13. Cause of Injury (Describe how and why the injury occurred) I had gotten up on Ladder to reach a ream of paper when my foot slipped and I fell off Ladder onto my right hip		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) Right Hip + Back	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584). <div style="text-align: center;"> Signature of Employee or Person Acting on His/Her Behalf</div>			
17. Statement of Witness (Describe what you saw, heard or know about this injury) I was walking by the supply room where I heard a crash. I observed Mrs. Parker on the floor. She advised me she had injured her back.			
18. Witness' Signature 	19. Witness' Address 10 Park Place Portsmouth Va. 23709	20. Date Signed (mo., day, year) 5/1/78	

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency NAVY		22. Bureau or Office Norfolk Naval Shipyard	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) Industrial Relations Office Portsmouth, Va 23709			
24. Regular Work Day Begins 7:20 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends 3:50 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day 8	26. Circle Days Paid Per Week S <input checked="" type="checkbox"/> (M) <input checked="" type="checkbox"/> (T) <input checked="" type="checkbox"/> (W) <input checked="" type="checkbox"/> (T) <input checked="" type="checkbox"/> (F) S
27. Date and Hour of Injury (mo., day, year) 4/30/78 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		28. Date Reporting Office Received Notice of Injury (mo., day, year) 5/1/78	29. Date and Hour Stopped Work (mo., day, year) 5/2/78
31. 45 Day Period Begins (mo., day, year) 5/2/78	32. Pay Rate When Employee Stopped Work \$5.00 per hour	33. Date and Hour Employee Returned to Work (mo., day, year) still out <input type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor At Time of Injury Gloria Spicer
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) 5/2/78	39. Name and Address of Physician First Providing Medical Care Dr. T. A. Baker 11 Armstrong Square Portsmouth, Va 23709		40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor Gloria Spicer	44. Title and Office Phone Number Head, Supply Dept		45. Date (mo., day, year) 5/10/78

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A - AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Dr T. A. Baker
11 Armstrong Rd.
Portsmouth, Va

2. EMPLOYEE'S NAME (Last, first, middle)

Parker, Mary H.

3. DATE OF INJURY
(mo., day, year)

4/30/78

4. OCCUPATION

Clerk-Typist

5. DESCRIPTION OF INJURY OR DISEASE

"I had gotten up on ladder to reach a ream of paper when my foot slipped and I fell about 4' injuring right h.p.

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

- ☒ A. FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.
- ☐ B. THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT, YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)

Billy Gallup

9. TITLE

Head, Employee Service

10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER

(804) 396-7886

11. DATE (mo., day, year)

5/1/78

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.

Dept or Agency

Bureau or Office

Local Address
(Including Zip Code)

STATEMENT OF OFFICIAL SUPERIOR

PART B - GENERAL

18. Name and Address of Reporting Office (Number, street, city, state, zip code)

Norfolk Naval Shipyard, Industrial Relations Office, Portsmouth, Va 23709

19. Pay Rate As Of:

Date of Injury



a. Base Pay

\$5.25 per hour

b. Subsistence

\$ per

c. Quarters

\$ per

d. Other (Specify)

\$ per

Date Employee Stopped Work



\$5.25 per hour

\$ per

\$ per

\$ per

20. If Employee Received Additional Pay, I.e. Premium, Sunday, Night Differential, Identify Type And Show Amount

Type

N/A

\$

per

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday

S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?

☒ Yes☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?

☐ Yes☐ No

24. Total Length of Employee's Federal Civilian Service

10 years

25. Inclusive Dates Employee Received Leave Pay For Any Part Of The Period Since Stopping Work

a. Annual Leave

b. Sick Leave

c. Other (Specify)

PART C - CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes

\$5.25 per hour

27. Inclusive Dates Regular Pay Continued During Period of Disability. Do Not Include Periods of Sick or Annual Leave

From: 5/1/78 Through: 6/14/78

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave

\$2,348.02

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate (Mo., day, year)

N/A

a. Base Pay

\$ per

b. Subsistence

\$ per

c. Quarters

\$ per

d. Other (Specify)

\$ per

PART D - COMPENSATION

30. Date And Hour All Pay Terminated (Mo., day, year)

6/15/78

☒ AM
☐ PM

31. Period For Which Compensation Is Claimed

From: 6/15/78 Through: 7/15/78

32. Deductions:

a. Was Employee Enrolled On Date Pay Stopped?

b. If Yes, Furnish Code Number.

c. If Yes, Give Date Through Which Deductions Were Last Made.

Health Benefits

☒ Yes ☐ No

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Optional Insurance

☐ Yes ☒ No

PART E - RETURN TO DUTY

33. Date And Hour Returned To Work (Mo., day, year)

still out

☐ AM
☐ PM

34. Pay Rate At Time Returned To Work

\$ per

35. Show Work Week On Return To Work If Other Than Monday Through Friday

S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F - CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor

Billy Dally

39. Title And Office Phone Number

Naval Employee Services
(804) 396-2408

40. Date (Mo., day, year)

6/16/78

CA-7
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		ATTENDING PHYSICIAN'S REPORT	
1. NAME OF INJURED EMPLOYEE (Last, first, middle) Parker, Mary H.		2. HOME MAILING ADDRESS (Number, street, city, state, zip code) 606 Meadow View Rd Portsmouth, Va 23709	
3. DATE AND HOUR OF INJURY (Mo., day, year) 4/30/78 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM 6/15/78 TO 7/15/78	
5. WHAT HISTORY OF INJURY (including disease caused by the employment) DID EMPLOYEE GIVE YOU? Fell off Ladder injuring right hip.			
6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)? Lumbosacral Spine Sprain Superimposed on spondylosis, Muscle spasms			
7. WHAT IS YOUR DIAGNOSIS? Same as above			
8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, DATE OF ADMISSION (Mo., day, year) DATE OF DISCHARGE		10. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. OPERATIONS (If any, describe type) N/A		12. DATE OPERATIONS PERFORMED (Mo., day, year) N/A	
13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? Examination, medication, physical therapy		14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? Unknown at this point	
15. DATE OF FIRST EXAMINATION (Mo., day, year) 5/2/78	16. DATES OF TREATMENT (Mo., day, year) 6/13/78 —		17. DATE OF DISCHARGE FROM TREATMENT (Mo., day, year) —
18. PERIOD OF DISABILITY (If termination date unknown, so indicate) (Mo., day, year) TOTAL DISABILITY FROM 4/30/78 TO Present PARTIAL DISABILITY FROM — TO —		19. DATE EMPLOYEE ABLE TO RESUME (Mo., day, year) LIGHT WORK N/A REGULAR WORK N/A	
20. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE BEEN ADVISED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, FURNISH DATE ADVISED.			
21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS. N/A			
22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.			
23. SIGNATURE OF PHYSICIAN T. R. Baker	24. ADDRESS (Number, street, city, state, zip code) 11 Armstrong Square Portsmouth, Va 23709		25. DATE OF REPORT (Mo., day, year) 6/14/78

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Rev. Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR		
16 IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR <small>(Mo., day, year)</small> <div style="text-align: right;"> <input type="checkbox"/> AM <input type="checkbox"/> PM </div>	17 SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY <div style="text-align: center; font-family: monospace; font-size: 1.2em;"> S M T W T F S </div>	
18 HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6. ON THE REVERSE SIDE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	19 IF ANSWER TO ITEM 18, IS YES, SHOW: AMOUNT \$ _____ TYPE OF PAYMENT _____ PERIOD FROM _____ THROUGH _____	
20 IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN <i>(i.e. change of plan or option, if additional deductions have been made by the agency, show amount and period)</i> <div style="font-size: 1.5em; text-align: center;">N/A</div>		
21 REMARKS		
22 SIGNATURE OF OFFICIAL SUPERIOR <div style="font-family: cursive; font-size: 1.2em;">Bella Gallego</div>	23. TITLE <div style="font-family: cursive; font-size: 1.2em;">Head, Employee Services</div>	24. DATE <small>(Mo., day, year)</small> <div style="font-family: cursive; font-size: 1.2em;">7/18/78</div>
<p>INSTRUCTIONS FOR INJURED EMPLOYEE</p> <ol style="list-style-type: none"> a. Items 1, through 15, on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by the OWCP. A copy of the form will be enclosed with each compensation check. Additional copies may be obtained from the OWCP or the employing agency. c. Employees are advised that fraudulent claims are punishable by a fine of not more than \$2,000, or imprisonment for not more than one year, or both. <p>INSTRUCTIONS FOR OFFICIAL SUPERIOR</p> <ol style="list-style-type: none"> a. The official superior must complete items 16, through 24, and forward the form to the appropriate OWCP office. b. The official superior must also complete items 1, through 6, on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3, on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form. <p style="margin-top: 20px;">If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.</p> <p>NOTE: DELAY IN SUBMITTING THIS FORM PROPERLY COMPLETED, OR WITHOUT SUPPORTING MEDICAL EVIDENCE, WILL DELAY PAYMENT OF COMPENSATION.</p>		

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT	
FOR INSTRUCTIONS SEE REVERSE SIDE			
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Parker, Mary H</i>		2. OWCP FILE NUMBER, IF KNOWN <i>A25-100000</i>	
3. HOME MAILING ADDRESS (Include zip code) <i>606 Meadow View Rd Portsmouth, VA 23709</i>		4. SOCIAL SECURITY NUMBER <i>218-04-1926</i>	
5. DATE AND HOUR OF INJURY (Mo., day, year) <i>4/30/78</i> <i>10:00</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM: <i>7/16/78</i> THROUGH: <i>8/16/78</i>	
7. DATE OF MOST RECENT EXAMINATION (Mo., day, year) <i>8/2/78</i>	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT <i>Chronic back problem</i>		11. STATE DIAGNOSIS <i>Lumbosacral Spine Sprain superimposed on spondylosithesis, muscle spasms</i>	
12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN? <i>Medication, physical therapy - 3 times a day</i>			
13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED? <i>Unknown</i>		14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY <i>N/A</i>	
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)		16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)	
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.)		18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.	
19. RECOMMENDATIONS AND PROGNOSIS <i>Continue to be rechecked on monthly basis Continue on medication for muscle spasms and continue physical therapy three times a week</i>			
20. ADDRESS (Include zip code) <i>11 Armstrong Square Portsmouth, Va</i>		21. IF YOU SPECIALIZE, INDICATE SPECIALTY <i>Orthopedics</i>	
22. SIGNATURE OF PHYSICIAN <i>T.D. Baker</i>		23. DATE OF REPORT (Mo., day, year) <i>8/3/78</i>	

Form CA-20a Revised Nov. 1974

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

December 1, 1979

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

This patient was examined by me on 12/1/79. Chief complaints continue to be that of stiffness and pain in the lower back region.

New X-rays were taken but revealed nothing new. Straight leg raising was 40° and muscle spasms were noted in lower lumbar region.

I feel the patient continues to be disabled from all work due to the 4/30/78 injury. If additional information is needed, please feel free to contact me.

Sincerely.

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

OOK
ERM CASE REVIEW
CASE

October 15, 1980

of Workers' Compensation
th Street, N.W.
gton, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

ir:

saw the above patient on 10/15/80. At that time she was
ining of pain and stiffness in the lower back. When she
, her gait favored the left side more than the right.

ation revealed limited range of motion. Muscle spasms
ue to be noted and I could not, at this time, obtain a
ht leg raising because of pain.

at to continue medication for muscle spasms and physical
y three times a week. I also recommend no work until
at is seen for next re-check.

Sincerely,

T. A. Baker, M. D.

.O:
k Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

November 20, 1981

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

Patient was seen 11/20/81 and continues to complain of pain and stiffness.

Physical examination noted straight leg raising of 60° and muscle spasms in lower lumbar region. A limited range of motion was also noted.

I feel patient would benefit from a whirlpool and have recommended she rent one. To remain out of work until she is rechecked in one month.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

September 25, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

The patient was in today for her monthly check-up. Complaints of pain and stiffness continue.

Examination revealed straight leg raising of 60°. No new X-rays were taken at this time. Muscle spasms continue in lower lumbar region and this puzzles me.

Due to the continuing pain, stiffness and muscle spasms in the lower lumbar region, I would like for my associate to examine this patient. Upon next monthly visit, I will have my associate evaluate. In the interim, continue same treatment plan and remain off work.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

October 29, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

The patient was in for her monthly re-check on 10/29/83. As I advised previously, I had my associate, Dr. Wood, examine her.

His findings with which I concur were limited range of motion, straight leg raising to 40°, muscle spasms and congenital spondylolisthesis. Dr. Wood recommended that muscle relaxers be discontinued and hot whirlpool baths be substituted treatment.

At this point, I feel patient continues to be disabled from all work and may eventually have to seek disability retirement.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

May 1, 1984

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

I have examined the above on this date. The patient continues to complain of pain and stiffness in the lower lumbar region.

Examination revealed straight leg raising to 60°. X-rays revealed nothing new. Muscle spasms were noted on lower lumbar region.

It is my opinion, based on the history of the injury and the current findings above, that the patient continues to be totally disabled from any type of work due to the occupational injury.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

PART B — PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in item 7)? ☐ YES ☒ NO
(If yes, indicate whether Part or Full Time and date able to resume such work)

☐ PART TIME ☐ FULL TIME Date (Mo., day, year)
Hours a day

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☒ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. (Including Preexisting Conditions.)

PHYSICAL LIMITATIONS

SEDENTARY — LIFTING 0 to 10 POUNDS
LIGHT — LIFTING 10 to 20 POUNDS
MODERATE — LIFTING 20 to 50 POUNDS
HEAVY — LIFTING 50 to 100 POUNDS
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:
EXPOSURE LIMITATIONS (Specify):

FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

Yes, patient continues to have muscle spasms in the lumbar region and chronic low back pain. Prognosis is fair

13. PERIOD OF DISABILITY (If termination date unknown, so indicate)

TOTAL DISABILITY FROM 4/30/78 TO present
PARTIAL DISABILITY FROM — TO —

14. DATE EMPLOYEE ABLE TO RESUME WORK (Mo., day, year)

LIGHT WORK ☐ ☒ undetermined
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED (Mo., day, year)

N/A

16. DIAGNOSIS OF CONDITION DUE TO INJURY

Lumbosacral spine sprain superimposed on spondylosithesis

17. DATE OF EXAMINATION

5/7/84

18. DATES OF FURTHER APPOINTMENTS, IF ANY

To recheck in one month

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

Dr. T. A. Baker

20. PROFESSIONAL DEGREE

MD

21. DATE (Mo., day, year)

5/10/84

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

From the choices below, select one of the courses of action that you would take.

- a. Notify OWCP that you are willing to offer Ms. Parker a limited duty assignment. Turn to page 212, Box 3.
- b. Since the medical condition has stabilized, request OWCP to do a LWEC rating. Turn to page 252, Box 2.
- c. Since the current medical evidence supports a job injury disability, review the next medical report (in 6 - 12 months) for any changes in medical status. Turn to page 211, Box 4.
- d. Ask OWCP to get a medical re-evaluation of Ms. Parker on the basis that one would expect comprehensive testing if the claimant has failed to respond to conservative treatment. Turn to page 253, Box 1.

1

The disability mentioned by the doctor (bending and stooping is painful) is not clearly related to the job injury (back strain) of 1980. Given the long time to recover from the back strain and the degenerative disk condition, the disability may be unrelated to the job injury.

Return to page 190 and make another selection.

2

Yes. This is the correct procedure. Since Ms. Williams has an accepted claim and is no longer an agency employee, only OWCP can act directly to get the needed medical evidence.

Turn to page 192 to see a sample letter to OWCP, then turn to page 193 to begin the next module.

3

There is some medical evidence. However, to be sufficient, the evidence would have to be:

objective (not subjective)
current (not more than 6 months old)
support total disability (not partial)

Return to page 188 and choose a different answer.

4

Although the doctor cites specific findings supporting job-related disability, there has been no explanation of why this condition has lasted 6 years. Dr. Baker reported on Sept. 1983 that she was puzzled over the lower back spasms. Some action seems called for.

Return to page 210 and try again.

1

Correct. The evidence is not sufficient.

Now turn to page 190 for the next task.

2

Not really. The doctor states that the patient is disabled for work, but offers no medical reason. The doctor maintains that bending and stooping are painful, but described no other disabilities. This is not total disability.

Return to page 190 and try again.

3

As long as the treating physician declares the claimant totally disabled and there is no prevailing medical evidence to the contrary, re-employment is not an option.

Return to page 210 and select another alternative.

4


No, since Ms. Williams is no longer an agency employee, OWCP would have to determine if and when Ms. Williams is able to return to work.

Return to page 191 for another choice.

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

You have selected names from your review of the chargeback list for cases to review. You are now reviewing the following file for Lucille Donaldson who was separated from the Postal Service on December 17, 1983. Review the following pages (214 - 231) from her case file. Assume today's date is February 8, 1985. Then answer the questions at the bottom of page 232.

If you need to refer to the Resource Book, consult pages 59 - 61.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) <i>Donaldson, Muelle</i>		2. Date of Birth <i>4/24/53</i>	3. <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
		4. Social Security Number <i>396-63-1117</i>	
5. Employee's Home Mailing Address (No., street, city, state, zip code) <i>5036 So. Racine Chicago IL 60602</i>		6. Home Telephone Area Code: <i>312</i> Number: <i>487-7719</i>	
7. Name and Address of Employing Agency <i>U.S. Postal Service North Suburban, MSB 8449 Palmer</i>		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) <i>Main floor</i>	
9. Date and Hour of Injury <i>3:20</i> (mo., day, year) <i>11/7/82</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	10. Date of This Notice (mo., day, year) <i>11/8/82</i>	11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation <i>RE</i>
13. Cause of Injury (Describe how and why the injury occurred) <i>Coming into building slipped on wet steps</i>		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) <i>Lower back & hip on right side</i>	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:			
<input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).			
 Signature of Employee or Person Acting on His/Her Behalf			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature		19. Witness' Address	20. Date Signed (mo., day, year)

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY			
21. Department or Agency <i>U.S. Postal Service</i>		22. Bureau or Office	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>Norfolk Suburban, MSC 8999 Palmer</i>			
24. Regular Work Day Begins <i>3:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM Ends <i>12:00</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week S <input checked="" type="radio"/> M <input checked="" type="radio"/> T <input checked="" type="radio"/> W <input checked="" type="radio"/> T <input checked="" type="radio"/> F <input checked="" type="radio"/> S
27. Date and Hour of Injury (mo., day, year) <i>11/7/82</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>11/7/82</i>	29. Date and Hour Stopped Work (mo., day, year) <i>11-7-82</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year)
31. 45 Day Period Begins (mo., day, year) <i>11/8/82</i>	32. Pay Rate When Employee Stopped Work \$ <i>9.02</i> per <i>hour</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <i>hasn't returned</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	34. Name of Supervisor At Time of Injury <i>Merrine Tate</i>
35. Was Employee In Performance of Duty At The Time of Injury? <input type="checkbox"/> Yes, <input checked="" type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report. <i>was coming into work</i>			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>11/7/82</i>	39. Name and Address of Physician First Providing Medical Care <i>Anthony Mass, M.D. 5507 So. Michigan</i>		40. Do Medical Reports Show Employee Is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation. <i>only know what employee stated on reverse of form,</i>			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor <i>Merrine Tate</i>	44. Title and Office Phone Number <i>Supv of Mails</i>		45. Date (mo., day, year) <i>11/9/82</i>

PART A – SUPERVISOR

Anthony Mass, (M.D)

Donaldson, Lucille

Re

NUMBER
336-63-1117

Cell centering work site

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ **STRESS** _____ **OTHER** _____

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDENTARY - LIFTING 0 to 10 POUNDS
LIGHT - LIFTING 10 to 20 POUNDS
MODERATE - LIFTING 20 to 50 POUNDS
HEAVY - LIFTING 50 to ~~100~~ POUNDS 70
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:

[illegible]

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in item 7)? ☐ YES ☐ NO
(If yes, indicate whether Part or Full Time and date able to resume such work)

☐ **PART TIME**
Hours a day _____☐ FULL TIME

Date (Mo., day, year)

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. (Including Preexisting Conditions.)

PHYSICAL LIMITATIONS

SEDENTARY – LIFTING 0 to 10 POUNDS

LIGHT – LIFTING 10 to 20 POUNDS

MODERATE – LIFTING 20 to 50 POUNDS

HEAVY – LIFTING 50 to 100 POUNDS

PULLING/PUSHING, CARRYING

REACHING OR WORKING ABOVE SHOULDER

WALKING	(HOURS)
---------	---	--------

STANDING	(HOURS)
----------	---	--------

SITTING	(HOURS)
---------	---	--------

STOOPING	(HOURS)
----------	----------

KNEELING (HOURS)

REPEATED BENDING	(HOURS)
------------------	---	--------

CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.

OTHER:

EXPOSURE LIMITATIONS (Specify):

[illegible]

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

Clmt has been advised to refrain from work

13. PERIOD OF DISABILITY (If termination date unknown, so indicate)

TOTAL DISABILITY FROM 11/7/82 TO present
PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK (Mo., day, year)

LIGHT WORK ☐

REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED (Mo., day, year)

16. DIAGNOSIS OF CONDITION DUE TO INJURY

lumbar sacral strain

17. DATE OF EXAMINATION

- 18. DATES OF FURTHER APPOINTMENTS, IF ANY**

19. SIGNATURE AND TYPED OR PRINTED NAME OF
PHYSICIAN

Anthony Maas, M.D.

- ## 20. PROFESSIONAL DEGREE

Family Practice

21. DATE (Mo., day, year)

11/7/82

PART A - AUTHORIZATION

NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Anthony Mass, M.D.
507 S Michigan Ave, Ill 60612

EMPLOYEE'S NAME (Last, first, middle)

Naldson, Lucille

3. DATE OF INJURY
(mo., day, year)

11/7/82

4. OCCUPATION

Reg. Clerk

DESCRIPTION OF INJURY OR DISEASE

Cont fell coming into lobby capturing
low back and right hip area

YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

- A- FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.
- B- THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT, YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT, PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)

Anthony Dixon

9. TITLE

RN

EMPLOYING AGENCY TELEPHONE NUMBER

86-5013

11. DATE (mo., day, year)

11/7/82

SEND ONE COPY OF YOUR REPORT TO (Fill in address):

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT,

Dept. or Agency

Bureau or Office

Local Address
(Including Zip Code)

PART B – ATTENDING PHYSICIAN'S REPORT14. ~~EMPLOYEE'S NAME~~ (Last, first, middle)

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT?
(If yes, please describe)

☐ Yes ☒ No

17. WHAT ARE YOUR FINDINGS (include results of x rays, laboratory tests, etc.) *Contusion on right hip*

18. WHAT IS YOUR DIAGNOSIS?

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED?
(Please explain your answer if there is doubt.)

☒ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION?

☐ Yes ☒ No

If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION
REQUIRED?

☐ Yes ☐ No

22. SURGERY (If any, describe type)

23. DATE SURGERY PERFORMED (mo.,
day, year)

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? None

26. DATE OF FIRST EXAMINATION (mo., day, year)

27. DATE(S) OF TREATMENT (mo., day, year)

28. DATE OF DISCHARGE FROM TREAT-
MENT (mo., day, year)

29. PERIOD OF DISABILITY (If termination date unknown, so indicate)
(mo., day, year)

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)

TOTAL DISABILITY: FROM 11/7
PARTIAL DISABILITY: FROM

TO
TO

LIGHT WORK
REGULAR WORK

31 IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED
(month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED

34. DO YOU SPECIALIZE?

☒ Yes ☐ No (If yes, state specialty

36. ADDRESS (Number, street, city, state, zip code)

37. PHYSICIAN'S SOCIAL SECURITY NUMBER

35. SIGNATURE OF PHYSICIAN

550.7 So Michigan

SECURITY NUMBER
-1-3/55

38. DATE OF REPORT
Monday, year 1951

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price		Amount	
			Cost	Per	\$	c
	TOTAL					

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Anthony Mass, M.D.

2. EMPLOYEE'S NAME (Last, first, middle)

Donaldson, Merrill

3. DATE OF INJURY
(Mo., day, year)

11-7-82

4. OCCUPATION

Re

5. SOCIAL SECURITY NUMBER

336-63-1117

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Full Catering Hldg

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ **STRESS** _____ **OTHER** _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDENTARY — LIFTING 0 to 10 POUNDS
LIGHT — LIFTING 10 to 20 POUNDS
MODERATE — LIFTING 20 to 50 POUNDS
HEAVY — LIFTING 50 to 100 POUNDS 70 lbs
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:

[illegible]

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

U.S. Postal Service
8999 Palmer
Caring Community Unit
Bedford Park 60103

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in Item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in Item 8).

PART B - PHYSICIAN																																																					
10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in Item 7)? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, indicate whether Part or Full Time and date able to resume such work)</i> <input type="checkbox"/> PART TIME <input type="checkbox"/> FULL TIME Date (Mo., day, year) Hours a day																																																					
11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. <i>(Including Preexisting Conditions.)</i>																																																					
<u>PHYSICAL LIMITATIONS</u> SEDENTARY – LIFTING 0 to 10 POUNDS LIGHT – LIFTING 10 to 20 POUNDS MODERATE – LIFTING 20 to 50 POUNDS HEAVY – LIFTING 50 to 100 POUNDS PULLING/PUSHING, CARRYING REACHING OR WORKING ABOVE SHOULDER WALKING (HOURS) STANDING (HOURS) SITTING (HOURS) STOOPING (HOURS) KNEELING (HOURS) REPEATED BENDING (HOURS) CLIMBING (HOURS) OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC. OTHER: EXPOSURE LIMITATIONS <i>(Specify):</i>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; font-size: small;">FULL RESTRICTION</th> <th style="text-align: center; font-size: small;">PARTIAL RESTRICTION</th> <th style="text-align: center; font-size: small;">NO RESTRICTION</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION																																																
FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION																																																			
12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS <div style="font-family: cursive; font-size: large; min-height: 40px;">severe lumbosacral strain) a muscle spasm</div>																																																					
13. PERIOD OF DISABILITY <i>(if termination date unknown, so indicate)</i> TOTAL DISABILITY FROM 11/7/82 TO present PARTIAL DISABILITY FROM TO	14. DATE EMPLOYEE ABLE TO RESUME WORK <i>(Mo., day, year)</i> LIGHT WORK <input type="checkbox"/> REGULAR WORK <input type="checkbox"/> } not yet																																																				
15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, FURNISH DATE ADVISED <i>(Mo., day, year)</i>																																																					
16. DIAGNOSIS OF CONDITION DUE TO INJURY <div style="font-family: cursive; font-size: large; min-height: 60px;">possible disc involvement has not responded to conservative care provided. will refer pt for an orthopedic examination</div>																																																					
17. DATE OF EXAMINATION	18. DATES OF FURTHER APPOINTMENTS, IF ANY																																																				
19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN <div style="font-family: cursive; font-size: large;">Anthony Macas</div>	20. PROFESSIONAL DEGREE <div style="font-family: cursive; font-size: large;">Family Practice</div>	21. DATE <i>(Mo., day, year)</i> <div style="font-family: cursive; font-size: large;">12/28/82</div>																																																			

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		ATTENDING PHYSICIAN'S REPORT	
1 NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Donaldson, Thelma</i>		2 HOME MAILING ADDRESS (Number, street, city, state, zip code) <i>5036 So. Racine</i>	
3. DATE AND HOUR OF INJURY (Mo., day, year) <i>11-7-82</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM <i>3:20</i>		4 PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM <i>12/23</i> TO <i>Present</i>	
5. WHAT HISTORY OF INJURY (including disease caused by the employment) DID EMPLOYEE GIVE YOU? <i>fell on steps entering work site</i>			
6. WHAT ARE YOUR FINDINGS (include results of x-rays, laboratory tests, etc.)? <i>acute L5 strain with right sided sciatica bruised right hip that has difficulty walking</i>			
7 WHAT IS YOUR DIAGNOSIS? <i>acute L5 strain w R sided sciatica possible HNP</i>			
8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, DATE OF ADMISSION (Mo., day, year) DATE OF DISCHARGE		10. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. OPERATIONS (If any, describe type) <i>NA</i>		12. DATE OPERATIONS PERFORMED (Mo., day, year) <i>NA</i>	
13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? <i>Conservative care, moist heat, diathermy, pain medication</i>		14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? <i>unable to determine</i>	
15. DATE OF FIRST EXAMINATION (Mo., day, year) <i>12-7-82</i>	16. DATES OF TREATMENT (Mo., day, year) <i>12/10 12/22, 1/5, 1/22</i>		17. DATE OF DISCHARGE FROM TREATMENT (Mo., day, year)
18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year) TOTAL DISABILITY FROM <i>11/7/82</i> TO <i>Present</i> PARTIAL DISABILITY FROM TO		19. DATE EMPLOYEE ABLE TO RESUME (Mo., day, year) LIGHT WORK <i>undetermined</i> REGULAR WORK	
20 IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE BEEN ADVISED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, FURNISH DATE ADVISED.			
21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.			
22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.			
23. SIGNATURE OF PHYSICIAN <i>Roschan (Chen)</i>	24. ADDRESS (Number, street, city, state, zip code) <i>530 Michigan Suite 1100</i>		25. DATE OF REPORT (Mo., day, year) <i>1/23/83</i>

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Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION Office of Workers' Compensation Programs (OWCP)		CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY	
PART A -- EMPLOYEE'S STATEMENT			
1. Name of Injured Employee (Last, first, middle) <i>Ronaldson, Michelle</i>		2. Social Security Number <i>336-63-1117</i>	3. OWCP File Number (if known) <i>A10-310564</i>
4. Is Claim Being Made For Wage Loss? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
6. Period Compensation Is Claimed As A Result Of Wage Loss (Mo., day, year) From: <i>12/23/83</i> Through: <i>present</i>		7. Has Any Pay Been Received For The Period Shown In Item 6? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, State Full Amount And Inclusive Dates For Such Period (Mo., day, year) \$ _____ From: _____ Through: _____	
8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Name And Address Of Such Party Or Insurance Carrier			9. Status Of Third Party Claim/Amount Of Recovery
10. Were You Ever In The Armed Forces Of The United States? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Furnish →	a. Service Number	b. Branch Of Service	c. Period Of Service (Mo., day, year) From: _____ Through: _____
11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Furnish →	a. Claim Number	b. Address of VA Office Where Claim Is Filed	c. Nature Of Disability And Monthly Payment
12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Furnish →	a. Claim Number	b. Date Annuity Began (Mo., day, year)	c. Amount of Monthly Payment \$ _____
13. List Your Dependents			
Name	Relationship	Date Of Birth	Living With You? (Yes/No)
<i>Richard</i>	<i>Husband</i>	<i>10/6/50</i>	<input checked="" type="checkbox"/>
<i>Garon</i>	<i>son</i>	<i>1/15/70</i>	<input checked="" type="checkbox"/>
14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.			
I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.			
15. Employee's Signature <i>Micelle Ronaldson</i>	16. Employee's Home Mailing Address (Include Zip Code) <i>5036 So. Racine apt 300</i>	17. Date (Mo., day, year) <i>01/23/83</i>	

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PART B - GENERAL

18. Name and Address of Reporting Office (Number, street, city, state, zip code)

19. Pay Rate As Of

Date of Injury

Date Employee Stopped Work

a. Base Pay

b. Subsistence

c. Quarters

d. Other (Specify)

\$ 28.50 per

\$ per

\$ per

\$ per

\$ 28.50 per

\$ per

\$ per

\$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night, Differential, Identify Type And Show Amount

Type 10% N.D.

\$ per

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday

S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?

☐ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?

☐ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service

25. Inclusive Dates Employee Received Leave Pay For Any Part Of The Period Since Stopping Work

a. Annual Leave

b. Sick Leave

c. Other (Specify)

PART C - CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes

\$ 28.50 per week

27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave

From: 11-8-82 Through 12/24/83

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability, Do Not Include Pay Received For Sick or Annual Leave

\$ 2,064.56

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate (Mo., day, year)

N/A

a. Base Pay

b. Subsistence

c. Quarters

d. Other (Specify)

\$ per

\$ per

\$ per

\$ per

PART D - COMPENSATION

30. Date And Hour All Pay Terminated (Mo., day, year)

12/23/83

☐ AM

☐ PM

31. Period For Which Compensation Is Claimed

From: 12/23/83 Through: present

32. Deductions:

a. Was Employee Enrolled On Date Pay Stopped?

b. If Yes, Furnish Code Number.

c. If Yes, Give Date Through Which Deductions Were Last Made.

Health Benefits

☒ Yes ☐ No

2011

Optional Insurance

☒ Yes ☐ No

PART E - RETURN TO DUTY

33. Date And Hour Returned To Work (Mo., day, year)

Never returned

☐ AM

☐ PM

34. Pay Rate At Time Returned To Work

\$ per

35. Show Work Week On Return To Work If Other Than Monday Through Friday

S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F - CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor

Reel Fritch

39. Title And Office Phone Number

Injury Comp Super

40. Date (Mo., day, year)

1/25/83

CA-7
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT	
FOR INSTRUCTIONS SEE REVERSE SIDE			
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Danielson, Melille</i>		2. OWCP FILE NUMBER, IF KNOWN <i>A10-362130</i>	
3. HOME MAILING ADDRESS (Include zip code) <i>5036 So. Racine Chgo 60602</i>		4. SOCIAL SECURITY NUMBER <i>336-631117</i>	
5. DATE AND HOUR OF INJURY (Mo., day, year) <i>11-7-82</i> <i>3:20</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM: <i>2/82</i> THROUGH: <i>Present</i>	
7. DATE OF MOST RECENT EXAMINATION (Mo., day, year) <i>4/10/83</i>	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT <i>low back strain of lumbar</i>		11. STATE DIAGNOSIS <i>Lumbar strain</i>	
12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN? <i>Physical therapy and electrotherapy treatments 3x weekly</i>			
13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED? <i>no heavy lifting</i>		14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY <i>N/A</i>	
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)		16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)	
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.)		18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.	
19. RECOMMENDATIONS AND PROGNOSIS <i>Unit is making good progress further diagnostic studies may be warranted</i>			
20. ADDRESS (Include zip code) <i>535 So. Michigan Suite 1100</i>		21. IF YOU SPECIALIZE, INDICATE SPECIALTY <i>Ortho</i>	
22. SIGNATURE OF PHYSICIAN <i>Roshan Chian</i>		23. DATE OF REPORT (Mo., day, year) <i>4/10/83</i>	

Form CA-20a Revised Nov. 1974

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		CLAIM FOR CONTINUING COMPENSATION ON ACCOUNT OF DISABILITY	
FOR INSTRUCTIONS SEE REVERSE SIDE			
STATEMENT OF INJURED EMPLOYEE			
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Donaldson, Melle</i>		2. OWCP FILE NUMBER, IF KNOWN <i>A10-362130</i>	
3. HOME MAILING ADDRESS (Include zip code) <i>5036 So. Racine Chgo, Ill 60602</i>		4. SOCIAL SECURITY NUMBER <i>336-63-1117</i>	
5. DATE AND HOUR OF INJURY (Mo., day, year) <i>11/7/82</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM <i>3:20</i>		6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM: <i>12/22</i> THROUGH: <i>Present</i>	
7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, COMPLETE ITEM 8.		8. AMOUNT RECEIVED \$ _____ DATES COVERED BY LEAVE PAY FROM _____ THROUGH: _____	
9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.			
a. DATES & HOURS WORKED	b. PAY RATE (per hour, day or week)	c. TOTAL AMOUNT EARNED	d. TYPE WORK PERFORMED
e. NAME & ADDRESS OF EMPLOYER			
10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING: REGISTRATION NO. DATE OF REGISTRATION OFFICE ADDRESS <div style="text-align: center; margin-top: 10px;"><i>N/A</i></div>			
11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING. <div style="text-align: center; margin-top: 10px;"><i>N/A</i></div>			
12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING. CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED <div style="text-align: center; margin-top: 10px;"><i>N/A</i></div>			
13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING: CLAIM NO. AMOUNT OF MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED <div style="text-align: center; margin-top: 10px;"><i>N/A</i></div>			
14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF <i>Melle Donaldson</i>		15. DATE (Mo., day, year) <i>4/10/83</i>	

For sale by the Superintendent of Documents, U.S. Government Printing Office
 Washington, D.C. 20402 Price \$5.45 per 100
 Stock Number 029-016-00022-1

Form CA-8 Revised Nov. 1974

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
May 30, 1983

To U. S. Postal Service:

I have continued to treat Ms. Lucille Donaldson conservatively. However, to date there has been no gross improvement. Ms. Donaldson continues to complain of unremitting low back pain and pain radiating to the lower extremities making it difficult for her to ambulate any long distances without sitting down to rest. Ms. Donaldson has not been able to clean her house or tend her garden since the onset of this injury.

Exam performed today revealed extreme tenderness of the low back with significant muscle spasm while at rest. Range of motion of the lumbar spine is restricted in all directions. Ankle jerks on the right were extremely weak compared to the left. Straight leg raising was restricted to 40° on left, 35° on right. Emg study taken this day was felt suggestive of a herniated nucleus pulposus. X-rays taken revealed degenerative disc disease at L4-L5 and small spur formations throughout the vertebrae which are felt not to be of any clinical significance.

Conclusion: Ms. Donaldson continues to have a lumbosacral sprain superimposed on degenerative disc disease which in conjunction has made the lumbosacral strain chronic and has not to date responded to the conservative treatment I have provided. Ms. Donaldson remains totally disabled for an indefinite period of time. I hope this report is sufficient for your needs.

Sincerely,

Kischan Chan, M. D.

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

U. S. POSTAL SERVICE
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607
June 10, 1983

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612

Dear Dr. Chan:

Thank you for your reports concerning Ms. Lucille Donaldson. Ms. Donaldson is employed as a regular clerk at this facility, where her duties consist of various tasks which require her physical fitness. However, we do have limited duty available for our injured employees. We are enclosing the OWCP 5 form to be completed by you once you believe Ms. Donaldson is no longer totally disabled.

We appreciate your continuing assistance in this case and will await your response.

Sincerely,

Bill Fritch
Injury Compensation Specialist

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
July 24, 1983

To U. S. Postal Service:

Ms. Donaldson has been under my care for an acute lumbrosacral strain with right sided sciatica. Emg and CT scan of 7-22-83 revealed abnormal findings suggestive of a herniated disc. Ms. Donaldson continues to be symptomatic with difficulty in walking and standing. Ms. Donaldson will be admitted shortly to the Presbyterian St. Luke Hospital to have a myelogram of the lumbar spine. If the myelogram reveals a herniated disc, Ms. Donaldson will be counseled concerning the surgical procedure that will render the most favorable results as it relates to her particular medical situation.

Kischan Chan, M. D.

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
November 15, 1983

To U. S. Postal Service:

Ms. Lucille Donaldson was hospitalized from 10/10/83 through 10/20/83 where she underwent surgery in the form of chymopapain injection to dissolve the HNP at L5-S₁. Ms. Donaldson will need a period of 4 to 6 mos. for recovery prior to returning to any working duties. Ms. Donaldson was examined this day by me and appears to be making steady progress. She is no longer hampered by the severe right leg pain of before but continues to be painful in the lower back. Straight leg testing is limited to 45° on right and 30° on left. Babinski test is negative. Left and right ankle jerks were tested and felt to be diminished. Tenderness of the right sacroiliac with continuing muscle spasm at rest. I will continue to treat Ms. Donaldson, however she will begin a course in PT 3X weekly starting next week at the Rehab Institute for the next 2 mos. I will see her again at that time.

Sincerely,

Kischan Chan, M. D.

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
May 11, 1984

To U. S. Postal Service:

I am in receipt of your inquiry concerning Ms. Donaldson whom I last examined on May 8, 1984. Ms. Donaldson has gained very little relief of the lower back pain previously described. Ms. Donaldson continues to be totally disabled and it is my opinion that this disability will be permanently totally disabling. Ms. Donaldson is only able to walk short distances and must have the aid of a cane when doing any walking. She continues on Motrin 500 mg, and Tylenol III for the pain. Ms. Donaldson's prognosis for returning to work is guarded. I have referred her to the Rehab Institute for a course in pain management.

Sincerely,

Kischan Chan, M. D.

TURN THE PAGE

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

- a. There is adequate medical evidence to justify total disability.

Yes _____ No _____

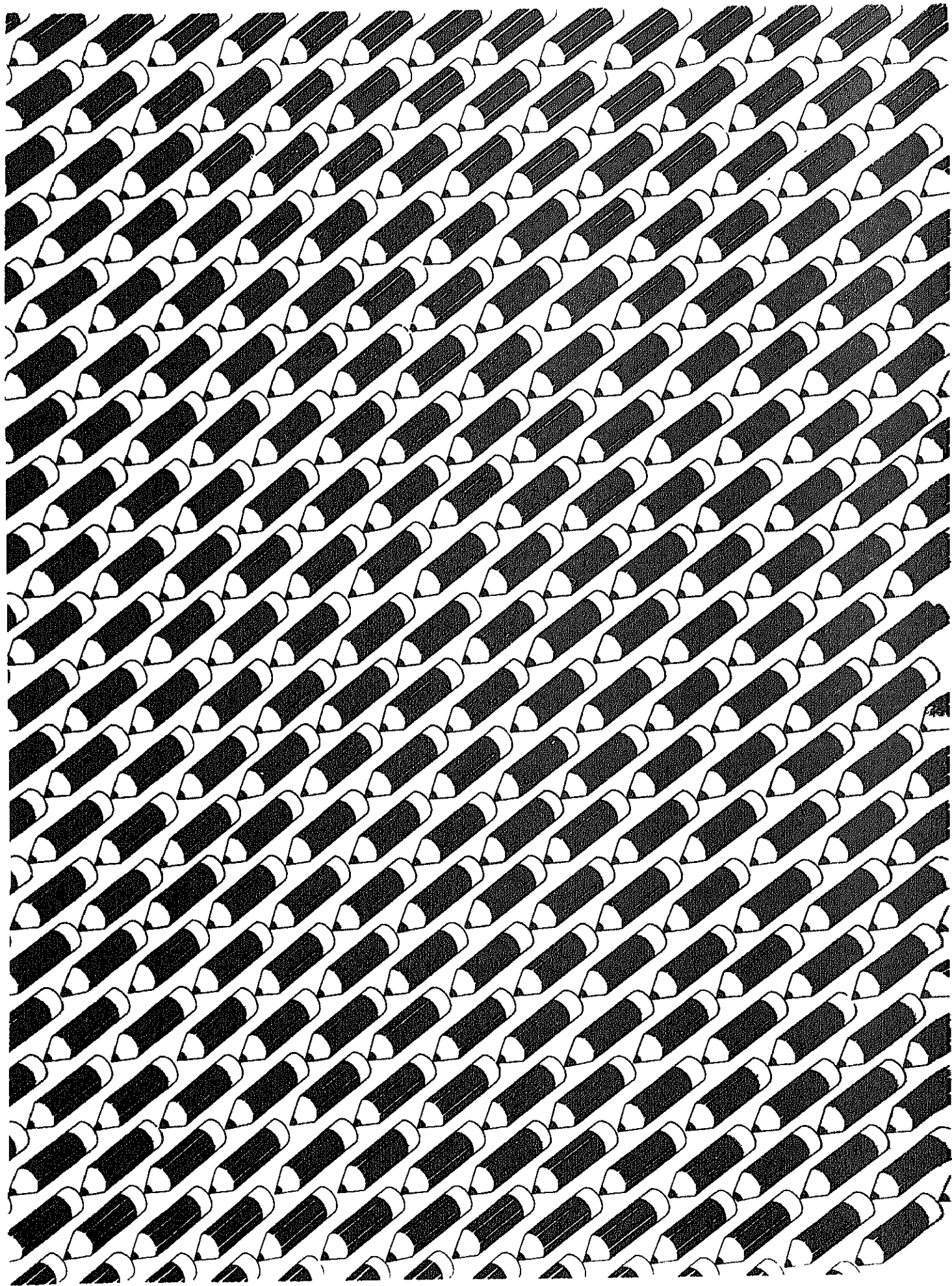
- b. If no, what specific questions do you want answered?

- c. If yes, what is your course of action?

WRITE YOUR ANSWERS BELOW.

AFTER YOU HAVE WRITTEN YOUR ANSWERS TURN TO PAGE 233 TO COMPARE YOUR ANSWERS WITH THE BOOK'S ANSWERS.

CASE MATERIAL ENDS HERE



TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

Answer:

- a. No, there is not adequate medical evidence to justify total disability.
- b. You would request a second opinion which would address:
 - 1. What are the objective findings that result in her current disability?
 - 2. To what extent are there disabilities as a result of the job related injury?
 - 3. Is claimant totally disabled from all employment, including sedentary employment?
 - 4. If not, what work restrictions are indicated?
- c. N/A

GO ON TO THE NEXT TASK.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

Review the documents which follow (pages 235 - 243) in the file of claimant Charles M. Murphy. Then answer the questions on page 244.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) <i>Murphy, Charles M.</i>		2. Date of Birth <i>1-11-53</i>	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number <i>261-03-4444</i>	
5. Employee's Home Mailing Address (No., street, city, state, zip code) <i>4736 W. Congress, Chicago, Ill 60630</i>		6. Home Telephone Area Code: <i>876</i> Number: <i>3091</i>	
7. Name and Address of Employing Agency <i>Chicago Main PO 433 E. Van Buren</i>		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) <i>8th floor MPO</i>	
9. Date and Hour of Injury <i>10:30</i> (mo., day, year) <i>1-7-83</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	10. Date of This Notice (mo., day, year) <i>1-7-83</i>	11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation <i>RMA</i>
13. Cause of Injury (Describe how and why the injury occurred) <i>Lifting a heavy mail bag</i>		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) <i>Lower back</i>	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work.			
<input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of EUSC 5584).			
<i>Charles M Murphy</i> Signature of Employee or Person Acting on His/Her Behalf			
17. Statement of Witness (Describe what you saw, heard or know about this injury) <i>I Juanita Seals was working next to Mr. Murphy when I heard him yell out I turned around and he was holding his back and told me he had injured himself</i>			
18. Witness' Signature <i>Juanita Seals</i>	19. Witness' Address <i>2234 So. Oakley</i>	20. Date Signed (mo., day, year) <i>1-7-83</i>	

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Name of Agency <i>115 RS</i>		22. Bureau or Office	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>115 RS Van Buren Chap, IL 60604</i>			
24. Regular Work Day begins <i>7:30</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM ends <i>3:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week S <input checked="" type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S
27. Date and Hour of Injury (mo., day, year) <i>1-7-83</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>1-7-83</i>	29. Date and Hour Stopped Work (mo., day, year) <i>1-7-83</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year)
31. 45 Day Period Begins (mo., day, year) <i>1-8-83</i>	32. Pay Rate When Employee Stopped Work \$ <i>11.35</i> per <i>hr</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor At Time of Injury <i>Rae Zitzler</i>
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>1-7-83</i>	39. Name and Address of Physician First Providing Medical Care <i>George Perry, M.D.</i> <i>840 W. Belmont</i> <i>Oak Lawn, IL 60453</i>		40. Do Medical Reports Show Employee Is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor <i>Rae Zitzler</i>		44. Title and Office Phone Number <i>Supr 886-3634</i>	45. Date (mo., day, year) <i>1-9-83</i>

U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs (OWCP)		REQUEST FOR EXAMINATION AND/OR TREATMENT	
PART A - AUTHORIZATION			
1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE <i>Dr. George Perry 8400 W. Clark</i> <i>Clark House 211 60453</i>			
2. EMPLOYEE'S NAME (Last, first, middle) <i>Murphy, Charles M</i>		3. DATE OF INJURY (mo., day, year) <i>1-7-83</i>	4. OCCUPATION <i>Regular Mailman</i>
5. DESCRIPTION OF INJURY OR DISEASE <i>Clmt was lifting a heavy mail pack (approx 70 lbs.) when he experienced immediate pain to the lower back</i>			
6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS: <input checked="" type="checkbox"/> A- FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL. <input type="checkbox"/> B- THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.			
7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM (Name of OWCP official)			
8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies) <i>Lydia Emporis</i>		9. TITLE <i>RN</i>	
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER <i>886-5000</i>		11. DATE (mo., day, year) <i>1/7/83</i>	
12. SEND ONE COPY OF YOUR REPORT TO (Fill in address) U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs		13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT. Dept. or Agency Bureau or Office Local Address (Including Zip Code)	

PART B - ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle) <i>Murphy, Charles</i>						
15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU? <i>It was lifting mail packs hurt back</i>						
16. IS THERE ANY HISTORY OR EVIDENCE OF PRE EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
17. WHAT ARE YOUR FINDINGS (include results of x-rays, laboratory tests, etc.)? <i>lumbar spine</i>			18. WHAT IS YOUR DIAGNOSIS? <i>Lumbar strain</i>			
19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
20. DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, date of admission (mo., day, year) Date of discharge (mo., day, year)			21. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
22. SURGERY (If any, describe type)			23. DATE SURGERY PERFORMED (mo., day, year)			
24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? <i>hot packs, muscle relaxants</i>			25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? <i>None anticipated</i>			
26. DATE OF FIRST EXAMINATION (mo., day, year) <i>1-7-83</i>	27. DATE(S) OF TREATMENT (mo., day, year) <i>1-7-83, 1-14-83 1-21,</i>		28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year) <i>Not discharged</i>			
29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year) TOTAL DISABILITY: FROM <i>1-7</i> TO <i>Present</i> PARTIAL DISABILITY: FROM _____ TO _____		30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year) LIGHT WORK <i>indefinite</i> REGULAR WORK				
31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FURNISH DATE ADVISED (month, day, year)						
32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS. <i>seen by Dr. Gilman orthopedist appt for 4/15/83</i>						
33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED. <i>Have advised not refrain from working until seen by ortho specialist</i>						
34. DO YOU SPECIALIZE? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state specialty) <i>Family Medicine</i>						
35. SIGNATURE OF PHYSICIAN <i>Geo Perry, M.D.</i>		36. ADDRESS (Number, street, city, state, zip code) <i>8400 West German Oak Lawn, IL 60453</i>		37. PHYSICIAN'S SOCIAL SECURITY NUMBER <i>13742</i>		
				38. DATE OF REPORT (mo., day, year) <i>1-27-83</i>		
39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.						
Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price		Amount	
			Cost	Per	\$	c
	TOTAL					

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

LETTER:

U. S. POSTAL SERVICE
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607

March 20, 1983

James Gillian, M.D.
Orthopedics, Unlimited
7600 S. Kostner
Ford City, Ill. 60433

Dear Dr. Gillian:

We are writing you concerning our employee, Mr. Charles M. Murphy, who was referred to you by Dr. George Perry. Mr. Murphy is a regular mailhandler. This position requires quite a bit of standing, walking, lifting, etc. However, we are able to provide Mr. Murphy with a sedentary position in keeping with any work restrictions you deem warranted. If Mr. Murphy is not totally disabled for all gainful employment, please complete the enclosed CA-17 form so we may extend Mr. Murphy a limited duty position.

Sincerely,

John E. Jacobson
Injury Compensation Unit

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A -- SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

James Sullivan, M.D.

2. EMPLOYEE'S NAME (Last, first, middle)

Murphy, Chas M

3. DATE OF INJURY
(Mo., day, year)

1-7-83

4. OCCUPATION

Rmtr

5. SOCIAL SECURITY
NUMBER

261-03-4444

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Lifting mail packs

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

Tractor trailers, must be able to lift up to 70 lbs

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD _____ NOISE _____ DUST _____
FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDENTARY -- LIFTING 0 to 10 POUNDS
LIGHT -- LIFTING 10 to 20 POUNDS
MODERATE -- LIFTING 20 to 50 POUNDS
HEAVY -- LIFTING 50 to 70 POUNDS *70 lbs*
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:

LITTLE OR NONE	MODERATE	OFTEN
		<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

Light duty work in a modified position is available

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

*Chicago APO
Injury Comp Unit
433 W. Van Buren
Chgo, Ill 60607*

**INSTRUCTIONS FOR COMPLETION AND
SUBMISSION OF DUTY STATUS REPORT**

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

PART B - PHYSICIAN																																																															
10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in item 7)? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>(If yes, indicate whether Part or Full Time and date able to resume such work)</i>																																																															
<input type="checkbox"/> PART TIME <small>Hours a day</small>	<input type="checkbox"/> FULL TIME	Date (Mo., day, year)																																																													
<i>will reevaluate in 4 wks</i>																																																															
11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. <i>(Including Preexisting Conditions)</i>																																																															
<u>PHYSICAL LIMITATIONS</u> SEDENTARY - LIFTING 0 to 10 POUNDS LIGHT - LIFTING 10 to 20 POUNDS MODERATE - LIFTING 20 to 50 POUNDS HEAVY - LIFTING 50 to 100 POUNDS PULLING/PUSHING, CARRYING REACHING OR WORKING ABOVE SHOULDER WALKING (HOURS) STANDING (HOURS) SITTING (HOURS) STOOPING (HOURS) KNEELING (HOURS) REPEATED BENDING (HOURS) CLIMBING (HOURS) OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC. OTHER EXPOSURE LIMITATIONS <i>(Specify)</i> .		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">FULL RESTRICTION</th> <th style="width: 33%;">PARTIAL RESTRICTION</th> <th style="width: 33%;">NO RESTRICTION</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION																																																									
FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION																																																													
12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS <div style="font-size: 1.2em; margin-top: 10px;"><i>C/O severe low back pain</i></div>																																																															
13. PERIOD OF DISABILITY <i>(if termination date unknown, so indicate)</i> TOTAL DISABILITY FROM <i>1/7/83</i> TO <i>indefinite</i> PARTIAL DISABILITY FROM _____ TO _____		14. DATE EMPLOYEE ABLE TO RESUME WORK (Mo., day, year) LIGHT WORK <input type="checkbox"/> REGULAR WORK <input type="checkbox"/>																																																													
15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, FURNISH DATE ADVISED (Mo., day, year)																																																															
16. DIAGNOSIS OF CONDITION DUE TO INJURY <div style="font-size: 1.2em; margin-top: 10px;"><i>C/Ls lower back</i></div> <div style="font-size: 1.2em; margin-top: 10px;"><i>Clmt will be attending PT 3x weekly</i></div>																																																															
17. DATE OF EXAMINATION <i>4/15/83</i>		18. DATES OF FURTHER APPOINTMENTS, IF ANY																																																													
19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN <i>Allan M.D.</i>		20. PROFESSIONAL DEGREE <i>Rtthopedics</i>																																																													
		21. DATE (Mo., day, year) <i>4/15/83</i>																																																													

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

U. S. POSTAL SERVICE
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607

May 1, 1983

James Gillian, M.D.
Orthopedics, Unlimited
7600 S. Kostner
Ford City, Ill. 60433

Dear Dr. Gillian:

We are writing you concerning our employee, Mr. Charles M. Murphy, who is continuing under your care. Thank you for your latest report dated 4-15-83 in which you report Mr. Murphy is totally disabled for all gainful employment. In order for us to further clarify Mr. Murphy's medical status please answer the following questions:

1. In your opinion, are there objective findings attributable to the job injury of 1-7-83?
2. If there are objective residuals, please list them.
3. In your opinion, specifically what are the residuals which preclude Mr. Murphy from returning to a modified sedentary non-competitive position?

We appreciate your continuing assistance in this case and will await your prompt response.

Sincerely,

John E. Jacobson
Injury Compensation Unit

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

James Gillian, M.D.
Orthopedics, Unlimited
7600 S. Kostner
Ford City, Ill. 60433
May 15, 1983

Mr. John E. Jacobson
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607

Mr. Charles Murphy continues to be totally disabled for work. He is continuing in physical therapy 2 X weekly. His improvement has and continues to be slow. Mr Murphy continues to have a painful back, and muscle spasm upon examination. Mr. Murphy reports that approximately one week ago while leaning over to tie his shoe, he was unable to straighten back up and has noticed increased pain in the lumbar area since this incident. I am giving Mr. Murphy a trial period of Darvon to help in alleviating his pain. Mr. Murphy will be reexamined in 6 weeks. At this time he remains totally disabled.

Sincerely,

James Gillian, M. D.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

Mr. Murphy continues on his agency's roll. Assume today's date is May 18, 1983.

What is the next step for you to take? Circle the letter of one of the courses of action below. Then turn to the page indicated.

- a. Schedule a Fitness for Duty examination for Mr. Murphy.
Turn to page 252, Box 4.
- b. The doctor clearly states that Mr. Murphy is totally disabled. Reevaluate after his next examination in six weeks. Turn to page 253, Box 3.
- c. Request OWCP to send Mr. Murphy for a second opinion.
Turn to page 273, Box 1.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 2

You have written the following letter to Dr. McNeil requesting a Fitness for Duty examination. The results of the Fitness for Duty examination follow. Review pages 246 - 249, then answer the questions on page 250.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 2

Rudolph McNeil
Orthopedic Surgeon
4355 Pratt Street
Chicago, Ill 60608
June 26, 1983

Mr. John E. Jacobson
Injury Compensation Unit
433 West Van Buren
Chicago, Illinois 60607

Dear Mr. Jacobson:

I examined Mr. Murphy in my office on 6/25/83 at which time Mr. Murphy appeared promptly for the exam. He entered the office with a brisk gait. However, upon noting my observation, his walking became slow and affected. Upon exam of the lumbar spine Mr. Murphy was extremely guarded in the range of motion exercise demonstrating no range of motion in the lumbar spine. Straight leg testing was restricted in all directions. Ankle jerks were found to be brisk and active. X-rays of the lumbar spine revealed no abnormalities. Emg, however, did suggest a higher reading in the left lower extremity, more so than on the right.

Conclusions: It is my opinion that Mr. Murphy does have a lumbrosacral strain resolving. However, this condition does not preclude him from returning to work in a limited duty status. I have completed the CA-17 form (attached) as requested. It should be noted, however, that Mr. Murphy views his disability as totally disabling and therefore it will be extremely difficult in getting him to return to any working duties. I have advised Mr. Murphy that he can return to work in a modified position and that your office says there is one available.

Thank you for having me examine this most interesting patient.

Sincerely,

Rudolph McNeil
Orthopedic Surgeon

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A — SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Rudolph W. McNeil
4355 Pratt Street Chicago, Ill. 60648

2. EMPLOYEE'S NAME (Last, first, middle)

Murphy, Charles M

3. DATE OF INJURY

(Mo., day, year)

1-7-83

4. OCCUPATION

R.M.N.

5. SOCIAL SECURITY NUMBER

261-034444

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Lifting mail sacks

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

Chgo. Fed. Mail. Sacks with hand operated trolleys. Mail is loaded to the top of 70 ft. high racks. Sacks are heavy.

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD _____ NOISE _____ DUST _____
FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDENTARY — LIFTING 0 to 10 POUNDS
LIGHT — LIFTING 10 to 20 POUNDS
MODERATE — LIFTING 20 to 50 POUNDS
HEAVY — LIFTING 50 to 100 POUNDS 70 lbs
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:

LITTLE OR NONE	MODERATE	OFTEN
		✓
		✓
		✓
		✓
	✓	
		✓
✓		✓
		✓
✓		✓
		✓
		✓

Light duty work in a modified. Position available.

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

PART B - PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK (Described in item 7)? ☐ YES ☒ NO
(If yes, indicate whether Part or Full Time and date able to resume such work)

☐ PART TIME ☐ FULL TIME Date (Mo., day, year)
Hours a day

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☒ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. (Including Preexisting Conditions.)

PHYSICAL LIMITATIONS

SEDENTARY - LIFTING 0 to 10 POUNDS

LIGHT - LIFTING 10 to 20 POUNDS

MODERATE - LIFTING 20 to 50 POUNDS

HEAVY - LIFTING 50 to 100 POUNDS

PULLING/PUSHING, CARRYING

REACHING OR WORKING ABOVE SHOULDER

WALKING (HOURS)

STANDING (HOURS)

SITTING (HOURS)

STOOPING (HOURS)

KNEELING (HOURS)

REPEATED BENDING (HOURS)

CLIMBING (HOURS)

OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.

OTHER:

EXPOSURE LIMITATIONS (Specify):

FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
		✓
		✓
✓		
✓		
	✓	
	✓	✓
	✓	
		✓
✓		
✓		
✓		
✓		
✓		

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY (If termination date unknown, so indicate)

TOTAL DISABILITY FROM TO

PARTIAL DISABILITY FROM 4/25 TO

14. DATE EMPLOYEE ABLE TO RESUME WORK (Mo., day, year)

LIGHT WORK ☐

REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☒ YES ☐ NO. IF YES, FURNISH DATE ADVISED (Mo., day, year)

Yes - I advised that he can return to light work.

16. DIAGNOSIS OF CONDITION DUE TO INJURY No lifting over 20 lbs 8 m day.

receiving lumbar spine strain.

17. DATE OF EXAMINATION

6/25/83

18. DATES OF FURTHER APPOINTMENTS, IF ANY

None

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

Rudolph McNeil

20. PROFESSIONAL DEGREE

M.D.

21. DATE (Mo., day, year)

6/25/83

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 2

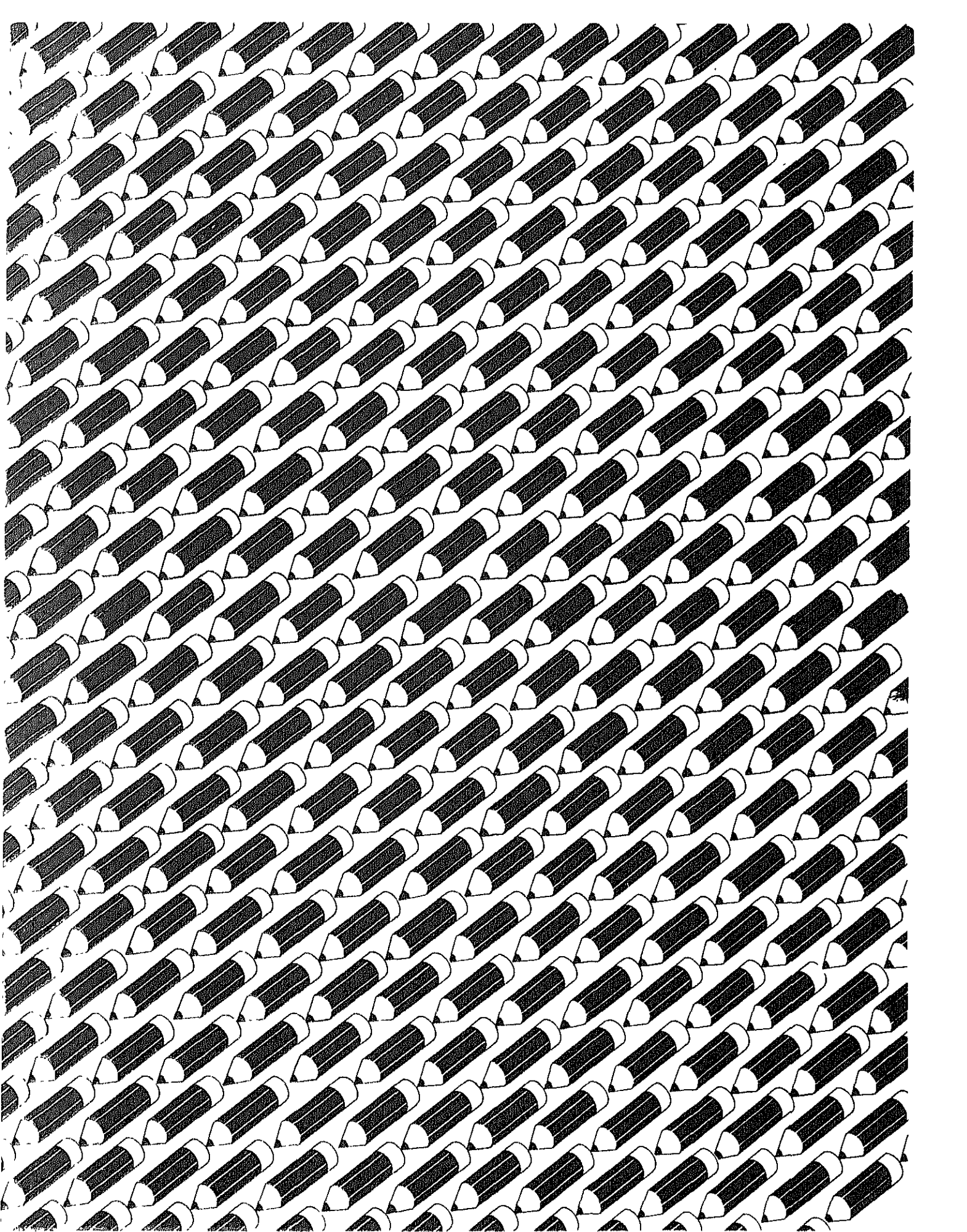
a) Is there any conflict?

b) Give your rationale.

WRITE YOUR ANSWERS BELOW.

AFTER YOU HAVE WRITTEN YOUR ANSWER, LOOK AT THE BOOK ANSWER ON
PAGE 251.

TASK MATERIAL ENDS HERE



TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 2

Answer:

- a. Yes, there is a conflict.
- b. Rationale. The treating physician says Mr. Murphy continues to be totally disabled, and the Fitness for Duty report states that Mr. Murphy can return to work in a limited duty capacity.

TURN TO PAGE 254 AND DO THE NEXT TASK.

1

No. Since Ms. Williams is on the periodic roll, and no longer an agency employee, OWCP would gather any medical evidence needed.

Return to page 190 for a different choice.

2

This is a possible course of action. However, after 6 years of the same status, it is unlikely that 6 or 12 more months will help much. More direct action seems called for.

Return to page 210 for another selection.

3

That's right.

The medical report is not adequate in any of the areas mentioned.

Now turn to page 191 for the next task.

4

Correct. Since the treating physician has not provided any objective findings for his opinion of total disability, you need another opinion. As an employee, he can be scheduled for a FFD.

Turn to page 245 for the following task.

1

That is correct. After this length of time (6 years) the doctor should be asked why a full range of diagnostic tests hasn't been considered.

Now turn to page 213 to begin the next case.

2

No. Since Ms. Williams is no longer an agency employee, you cannot order a Fitness for Duty exam.

Return to page 191 and choose again.

3

Not quite. The doctor certainly claims total disability. However, in response to your direct request for objective findings and specific residuals which prevent working, he did not respond adequately. He only pointed out subjective findings of pain. You may have to get the information elsewhere.

Return to page 244 and try again.

4

Not really. The doctor does indicate that the patient is suffering from back strain, degenerative disk and diabetes. But the reasons cited for disability are subjective, that is, the patient's complaints of pain. This does not meet the criteria of objective findings.

Return to page 190 for another choice.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 3

What steps would you take to resolve the conflict? Circle the letter below of the answer you select. Then turn to the page listed next to your answer.

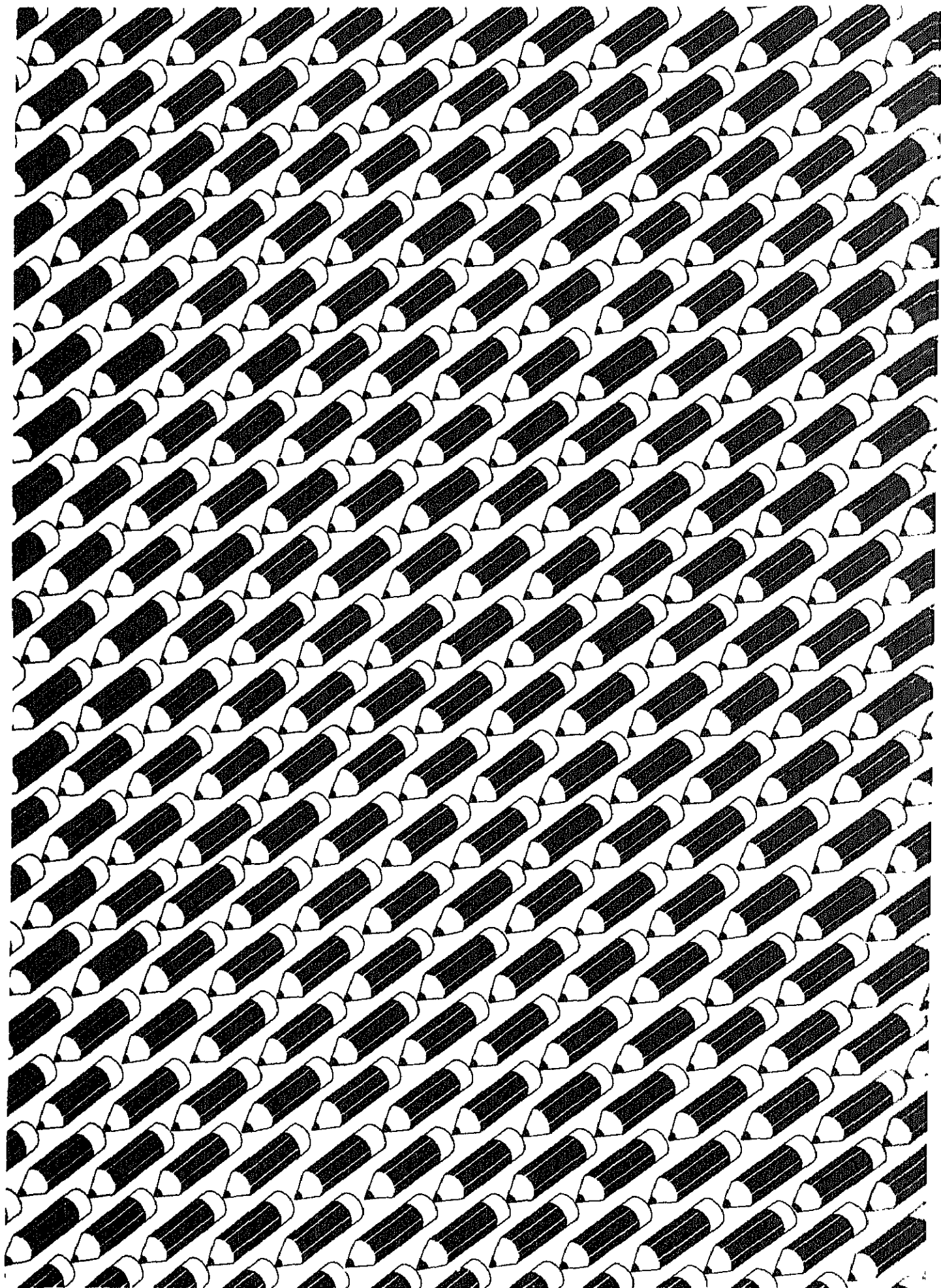
- a. Although the treating physician claimed total disability, it was based on only the patient's subjective pain. On the other hand, the FFD report shows objective findings, so you may use the FFD and assign Mr. Murphy to light duty. Turn to page 301, Box 3.
- b. There is a clear conflict of medical opinion and you would have to write OWCP, enclosing the medical reports and requesting an impartial medical evaluation. Turn to page 273, Box 2.
- c. Since there is some conflict, you can require the claimant to go to a third doctor whose opinion will resolve the problem. Turn to page 300, Box 1.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 4

List below the points you would make in your letter to OWCP.

AFTER YOU HAVE LISTED THE POINTS, TURN TO PAGE 256 TO READ THE
BOOK ANSWER.

END OF CASE MATERIAL



TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 4

Answer:

1. Claimant Charles Murphy has continued under treatment of Dr. James Gillian who has provided conservative care through the present.
2. Dr. Gillian has continued to support total disability from the date of injury through the present.
3. Mr. Murphy was sent for a Fitness for Duty exam performed by Ortho Rudolph McNeil (report enclosed). Dr. McNeil reports that Mr. Murphy is not totally disabled for all gainful employment and that he could return to work in a limited duty position illustrated in the enclosed CA-17.
4. Mr. Murphy was informed by Dr. McNeil that he can return to work in a limited duty position and that there is a modified position available.
5. We are requesting a full review of this case and that the medical conflict which now exists be resolved by an impartial medical examination to be scheduled by OWCP.

TURN THE PAGE TO BEGIN A NEW MODULE.

REHABILITATION

As in the previous modules, you will be given a case and a series of tasks. For the tasks in this module you will be asked to:

- a. Make an initial decision about the case on the basis of the information given, and
- b. Decide what action you will take to resolve the case.

TURN THE PAGE TO BEGIN THE MODULE ON REHABILITATION.

TASK BOOK
REHABILITATION
PERRY CASE
TASK 1

No new resource material is required for this first task. If you wish to refer back to the Resource Book, consult pages 58 - 63.

Review the case file for Mr. Bill Perry on pages 259 - 271. Then turn to page 272 to do the task.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) <i>Perry, Bill W.</i>		2. Date of Birth <i>9/20/40</i>	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
4. Social Security Number <i>223-42-3514</i>		5. Employee's Home Mailing Address (No., street, city, state, zip code) <i>102 Lilac Ave Norfolk, Va 23709</i>	
6. Home Telephone Area Code: <i>804</i> Number: <i>587-1057</i>		7. Name and Address of Employing Agency <i>Norfolk Naval Shipyard Industrial Relations Office Portsmouth, Va 23709</i>	
8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) <i>machine shop Bldg 171</i>		9. Date and Hour of Injury <i>8:30</i> (mo., day, year) <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM <i>5/10/79</i>	
10. Date of This Notice (mo., day, year) <i>5/10/79</i>		11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	
12. Employee's Occupation <i>machinist</i>		13. Cause of Injury (Describe how and why the injury occurred) <i>I was working on the conveyor belt when it was switched on and caught my right arm & hand.</i>	
14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) <i>Right Arm & Hand (Laceration & Strain)</i>		15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.	
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:			
<input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 6584).			
<i>Bill W. Perry</i> Signature of Employee or Person Acting on His/Her behalf			
17. Statement of Witness (Describe what you saw, heard or know about this injury)			
18. Witness' Signature		19. Witness' Address	
		20. Date Signed (mo., day, year)	

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY			
21. Department or Agency <i>NAVY</i>		22. Bureau or Office <i>Norfolk Naval Shipyard</i>	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>Norfolk Naval Shipyard, Industrial Relations Office, Portsmouth, Va 23709</i>			
24. Regular Work Day Begins <i>7:30</i> <input type="checkbox"/> AM <input type="checkbox"/> PM Ends <i>4:00</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week <i>S M T W T F S</i>
27. Date and Hour of Injury (mo., day, year) <i>5/10/79</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>5/10/79</i>	29. Date and Hour Stopped Work (mo., day, year) <i>5/10/79</i>
30. If Pay Has Been Terminated, Give Date (mo., day, year)			
31. 45 Day Period Begins (mo., day, year) <i>5/11/79</i>	32. Pay Rate When Employee Stopped Work <i>\$10.00 per hour</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <i>Still out</i> <input type="checkbox"/> AM <input type="checkbox"/> PM	34. Name of Supervisor At Time of Injury
35. Was Employee In Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) <i>5/10/79</i>	39. Name and Address of Physician First Providing Medical Care <i>Dr. Douglas Fairbanks 203 Medical Towers Norfolk, Va 23709</i>		40. Do Medical Reports Show Employee is Disabled For Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation For Basis of Controversy (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.			
43. Signature of Supervisor <i>Billy L. Gallup</i>		44. Title and Office Phone Number <i>Asst. Employee Services (841) 396-7886</i>	45. Date (mo., day, year) <i>5/15/79</i>

U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs (OWCP)		REQUEST FOR EXAMINATION AND/OR TREATMENT	
PART A - AUTHORIZATION			
1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE <i>Dr Douglas Fairbanks 203 Medical Towers Norfolk, Va 23109</i>			
2. EMPLOYEE'S NAME (Last, first, middle) <i>Perry, Bill W</i>		3. DATE OF INJURY (mo., day, year) <i>5/10/79</i>	4. OCCUPATION <i>machinist</i>
5. DESCRIPTION OF INJURY OR DISEASE <i>"was working on the conveyor belt when it was switched on and caught my right arm and hand."</i>			
6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS <input checked="" type="checkbox"/> A- FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL. <input type="checkbox"/> B- THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.			
7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM <div style="text-align: center;">(Name of OWCP official)</div>			
8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)		9. TITLE	
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER <i>(804) 396 7886</i>		11. DATE (mo., day, year) <i>5/10/79</i>	
12. SEND ONE COPY OF YOUR REPORT TO (Fill in address) U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs		13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT. Dept. or Agency <i>Navy</i> Bureau or Office <i>Naval Air Station</i> Local Address (Including Zip Code) <i>Portsmouth, Va 23709</i>	

FORM CA-16
(REV. DEC 1974)

PART B - ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle) <i>Perry, Bill W.</i>							
15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU? <i>Injured right arm and hand in conveyor belt.</i>							
16. IS THERE ANY HISTORY OR EVIDENCE OF PRE EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
17. WHAT ARE YOUR FINDINGS (include results of x rays, laboratory tests, etc.)? <i>swelling, laceration of right hand</i>				18. WHAT IS YOUR DIAGNOSIS? <i>Sprain arm, right Laceration right hand</i>			
19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
20. DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, date of admission (mo., day, year) Date of discharge (mo., day, year)				21. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
22. SURGERY (If any, describe type) <i>Stitches to close laceration</i>				23. DATE SURGERY PERFORMED (mo., day, year) <i>5/10/79</i>			
24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? <i>Medication for pain, physical therapy</i>				25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? <i>Unknown</i>			
26. DATE OF FIRST EXAMINATION (mo., day, year) <i>5/10/79</i>		27. DATE(S) OF TREATMENT (mo., day, year)		28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)			
29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year) TOTAL DISABILITY: FROM <i>5/10/79</i> TO <i>Continuing</i> PARTIAL DISABILITY FROM TO				30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year) LIGHT WORK <i>N/A</i> REGULAR WORK			
31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, FURNISH DATE ADVISED (month, day, year)							
32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.							
33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.							
34. DO YOU SPECIALIZE? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state specialty) <i>Orthopedics</i>							
35. SIGNATURE OF PHYSICIAN <i>Douglas Fontaine</i>			36. ADDRESS (Number, street, city, state, zip code) <i>203 Medical Towers Norfolk, Va 23709</i>			37. PHYSICIAN'S SOCIAL SECURITY NUMBER <i>031-03-3333</i>	
			38. DATE OF REPORT (mo., day, year) <i>5/12/79</i>				
39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.							
Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price		Amount		
			Cost	Per	\$	¢	
<i>5/10/79</i>	<i>Initial Exam</i>	<i>1</i>	<i>150</i>	<i>00</i>	<i>150</i>	<i>00</i>	
TOTAL							

STATEMENT OF OFFICIAL SUPERIOR

PART B - GENERAL

18. Name and Address of Reporting Office (Number, street, city, state, zip code)

Norfolk Naval Shipyard, Industrial Relations, Portsmouth, Va 23709

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
Date of Injury →	\$ 10.00 per hour	\$ per	\$ per	\$ per
Date Employee Stopped Work →	\$ 10.00 per hour	\$ per	\$ per	\$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount

Type N/A \$ per

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday

S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?

☒ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?

☒ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service

6 YRS

25. Inclusive Dates Employee Received Leave Pay For Any Part Of The Period Since Stopping Work

a. Annual Leave

b. Sick Leave

c. Other (Specify)

PART C - CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes

\$ 10.00 per hour

27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave

From: 5/11/79 Through: 6/26/79

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability, Do Not Include Pay Received For Sick or Annual Leave

\$

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate (Mo., day, year)

a. Base Pay

b. Subsistence

c. Quarters

d. Other (Specify)

\$ per

\$ per

\$ per

\$ per

PART D - COMPENSATION

30. Date And Hour All Pay Terminated (Mo., day, year)

6/27/79

☐ AM4:00 ☒ PM

31. Period For Which Compensation Is Claimed

From: 6/27/79

Through: Continuing

32. Deductions:

a. Was Employee Enrolled On Date Pay Stopped?

b. If Yes, Furnish Code Number.

c. If Yes, Give Date Through Which Deductions Were Last Made.

Health Benefits

☒ Yes ☐ No

Optional Insurance

☐ Yes ☒ No

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PART E - RETURN TO DUTY

33. Date And Hour Returned To Work (Mo., day, year)

Still Out

☐ AM☐ PM

34. Pay Rate At Time Returned To Work

\$ per

35. Show Work Week On Return To Work If Other Than Monday Through Friday

S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F - CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor

Betsy Gallup

39. Title And Office Phone Number

Head, Employee Services
(804) 396-5808

40. Date (Mo., day, year)

6/28/79

CA-7

Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT	
FOR INSTRUCTIONS SEE REVERSE SIDE			
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Perry, Bill W.</i>		2. OWCP FILE NUMBER, IF KNOWN <i>A25-505142</i>	
3. HOME MAILING ADDRESS (Include zip code) <i>102 Ridge Ave Norfolk, Va 23709</i>		4. SOCIAL SECURITY NUMBER <i>223-42-3544</i>	
5. DATE AND HOUR OF INJURY (Mo., day, year) <i>5/10/79</i> <i>8:30</i> AM <input type="checkbox"/> PM		6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM: <i>8/1/79</i> THROUGH: <i>Continuing</i>	
7. DATE OF MOST RECENT EXAMINATION (Mo., day, year) <i>7/31/79</i>	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT <i>Sprain Right Arm with possible tendon & nerve damage, healing laceration</i>		11. STATE DIAGNOSIS <i>Same as item 10</i>	
12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN? <i>Re-evaluation monthly</i>			
13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED? <i>Unknown</i>		14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY <i>Arthritis, left foot Persistent obesity Post-femoral iliac bypass</i>	
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)		16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)	
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.)		18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.	
19. RECOMMENDATIONS AND PROGNOSIS			
20. ADDRESS (Include zip code)		21. IF YOU SPECIALIZE, INDICATE SPECIALTY	
22. SIGNATURE OF PHYSICIAN <i>Dr. Douglas Fairbanks</i>		23. DATE OF REPORT (Mo., day, year) <i>7/31/79</i>	

Form CA-20a Revised Nov. 1974

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		CLAIM FOR CONTINUING COMPENSATION ON ACCOUNT OF DISABILITY	
FOR INSTRUCTIONS SEE REVERSE SIDE			
STATEMENT OF INJURED EMPLOYEE			
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Perry, Bill W.</i>		2. OWCP FILE NUMBER, IF KNOWN <i>A25-505142</i>	
3. HOME MAILING ADDRESS (Include zip code) <i>102 2nd Ave Naples, Va 23709</i>		4. SOCIAL SECURITY NUMBER <i>223-42-3514</i>	
5. DATE AND HOUR OF INJURY (Mo., day, year) <i>5/10/79 8:30</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM <i>8/1/79</i> THROUGH <i>continuing</i>	
7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, COMPLETE ITEM 8		8. AMOUNT RECEIVED \$ _____ DATES COVERED BY LEAVE PAY FROM _____ THROUGH _____	
9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.			
a DATES & HOURS WORKED	b PAY RATE (per hour, day or week)	c TOTAL AMOUNT EARNED	d TYPE WORK PERFORMED
		<i>N/A</i>	
e NAME & ADDRESS OF EMPLOYER			
10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:			
REGISTRATION NO	DATE OF REGISTRATION	OFFICE ADDRESS	
		<i>N/A</i>	
11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.			
<i>N/A</i>			
12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING			
CLAIM NO	NATURE OF DISABILITY AND MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED	
		<i>N/A</i>	
13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:			
CLAIM NO	AMOUNT OF MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED	
		<i>N/A</i>	
14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF <i>Bill W. Perry</i>		15. DATE (Mo., day, year) <i>8/1/79</i>	

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Stock Number 0-79-036-00022-4

Form CA-8 Revised Nov. 1974

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR (Mo., day, year) *Still Not* ☐ AM ☐ PM

17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY

| S | M | T | W | T | F | S |

18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6. ON THE REVERSE SIDE?

☐ YES ☒ NO

19. IF ANSWER TO ITEM 18. IS YES, SHOW:

AMOUNT \$

TYPE OF PAYMENT

PERIOD FROM _____ THROUGH _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN (i.e. change of plan or option, if additional deductions have been made by the agency, show amount and period.)

21. REMARKS

22. SIGNATURE OF OFFICIAL SUPERIOR

Billy Gallup

23. TITLE

Head, Employee Services Div

24. DATE

(Mo., day, year)

8/1/79

INSTRUCTIONS FOR INJURED EMPLOYEE

- Items 1, through 15, on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.
- The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by the OWCP. A copy of the form will be enclosed with each compensation check. Additional copies may be obtained from the OWCP or the employing agency.
- Employees are advised that fraudulent claims are punishable by a fine of not more than \$2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

- The official superior must complete items 16, through 24, and forward the form to the appropriate OWCP office.
- The official superior must also complete items 1, through 6, on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3, on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: DELAY IN SUBMITTING THIS FORM PROPERLY COMPLETED, OR WITHOUT SUPPORTING MEDICAL EVIDENCE, WILL DELAY PAYMENT OF COMPENSATION.

U S DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION Office of Workers' Compensation Programs		ATTENDING PHYSICIAN'S REPORT	
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Perry, Bill W.</i>		2. HOME MAILING ADDRESS (Number, Street, City, State, Zip Code) <i>1635 S. 1st St. N. 1st St. 23709</i>	
3. DATE AND HOUR OF INJURY (Mo., Day, Year) <i>5/10/79 8:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., Day, Year) FROM <i>5/10/79</i> TO <i>Continuing</i>	
5. WHAT HISTORY OF INJURY (Including disease caused by the employment) DID EMPLOYEE GIVE YOU? <i>Injured at arm and hand in a conveyor belt</i>			
6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)? <i>Spasm right arm with possible tendon & nerve damage, but healed laceration</i>			
7. WHAT IS YOUR DIAGNOSIS? <i>None or none</i>			
8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, DATE OF ADMISSION (Mo., Day, Year) DATE OF DISCHARGE		10. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. OPERATIONS (If any, describe type) <i>Closure of laceration</i>		12. DATE OPERATIONS PERFORMED (Mo., Day, Year) <i>5/10/79</i>	
13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?		14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? <i>Unknown</i>	
15. DATE OF FIRST EXAMINATION (Mo., Day, Year) <i>5/10/79</i>	16. DATES OF TREATMENT (Mo., Day, Year)		17. DATE OF DISCHARGE FROM TREATMENT (Mo., Day, Year) <i>N/A</i>
18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year) TOTAL DISABILITY: FROM <i>5/10/79</i> TO <i>Continuing</i> PARTIAL DISABILITY: FROM _____ TO _____		19. DATE EMPLOYEE ABLE TO RESUME (Mo., Day, Year) LIGHT WORK REGULAR WORK	
20. ADVISE IF EMPLOYEE IS ABLE TO RESUME WORK <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, FURNISH DATE ADVISED.			
21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.			
22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.			
23. SIGNATURE OF PHYSICIAN <i>Douglas L. Leland</i>	24. ADDRESS (Number, Street, City, State, Zip Code) <i>203 Medical Center N. 1st St. 23709</i>		25. DATE OF REPORT (Mo., Day, Year) <i>7/5/80</i>

CA-20
(REV. AUG. 1976)

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT	
FOR INSTRUCTIONS SEE REVERSE SIDE			
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <i>Harry Ruff W</i>		2. OWCP FILE NUMBER, IF KNOWN <i>725-505142</i>	
3. HOME MAILING ADDRESS (Include zip code) <i>102 Liles Ave Burlington 23709</i>		4. SOCIAL SECURITY NUMBER <i>223-42-3574</i>	
5. DATE AND HOUR OF INJURY (Mo, day, year) <i>5/10/79</i> <i>8:30</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo, day, year) FROM <i>5/10/79</i> THROUGH <i>Present</i>	
7. DATE OF MOST RECENT EXAMINATION (Mo, day, year) <i>10/21/81</i>	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT <i>Spinal - Lt leg with possible tendon + nerve damage</i>		11. STATE DIAGNOSIS <i>herniated disc L5</i>	
12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN? <i>Medication, physical</i>			
13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED? <i>Unknown</i>		14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS, WHICH IS NOT RELATED TO THIS INJURY <i>Arthritis left foot chronic back pain, intermittent post-traumatic stress disorder</i>	
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo, day, year)		16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo, day, year)	
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.) <i>N/A</i>		18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS	
19. RECOMMENDATIONS AND PROGNOSIS <i>Prognosis guarded</i>			
20. ADDRESS (Include zip code)		21. IF YOU SPECIALIZE, INDICATE SPECIALTY <i>Orthopedics</i>	
22. SIGNATURE OF PHYSICIAN <i>Douglas J. Finkbeiner</i>		23. DATE OF REPORT (Mo., day, year) <i>10/25/81</i>	

Form CA-20a Revised Nov. 1974

TASK BOOK
REHABILITATION
PERRY CASE
TASK 1

Assume today's date is January 14, 1984. Mr. Perry is no longer on the agency's rolls. If you wish to refer to the Resource, consult pages 58 ~ 63.

Why is there reason to question compensation for disability?
Circle the letter below of the best answer.

- a. There is inadequate medical justification for total disability. Turn to page 300, Box 2.
- b. The claimant's current disability may be unrelated to the job injury. Turn to page 301, Box 2.
- c. The claimant is now able to do light duty work. Turn to page 329, Box 4.
- d. There is a concurrent condition that accounts for his present disability. Turn to page 326, Box 1.

1

Since you have not been able to get objective findings, you do need another source. However this isn't the most direct way.

Return to page 244 for an alternative.

2

That is correct. The conflict is clear and only OWCP can resolve it.

Turn to page 255 for the next task.

3

No. The medical report dated 3/14/81 is over two years old as of Dec. 4, 1983. A medical report more than 6 months old should not be used to justify disability.

Return to page 190 for another choice.

4

TASK BOOK
REHABILITATION
PERRY CASE
TASK 2

Read pages 64 - 71 in the Resource.

What steps would you take now? Select one of those listed below.

- a. Schedule a Fitness for Duty exam for Mr. Perry and with the work limitations obtained, design a light duty job. Turn to page 326, Box 3.
- b. Request that OWCP get work restrictions from the attending physician and modify a job to accommodate them. Turn to page 301, Box 1.
- c. Ask OWCP to have the attending physician identify restrictions due to occupational injury and modify a job to meet them. Turn to page 327, Box 3.
- d. Have OWCP get from the doctor, work restrictions resulting from pre-existing conditions and job related injury and design a light duty job to suit them. Turn to page 300, Box 4.

TASK BOOK
REHABILITATION
PERRY CASE
TASK 3

Read pages 72 - 75 in the Resource.

Read the Form OWCP 5 which follows on page 276. Then go to page 277 to do the task.

1. Injured workers' name (First, middle, last)

2. OWCP No.

A25-505142

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY									
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8	
a. Sitting	✓										✓	
b. Walking		✓				✓						
c. Lifting		✓			✓							
d. Bending		✓		✓								
e. Squatting		✓		✓								
f. Climbing		✓		✓								
g. Kneeling		✓		✓								
h. Twisting		✓			✓							
i. Standing	✓	✓						✓				

4. Check the lifting restriction.

☐ 0-10 lbs. ☒ 10-20 lbs. ☐ 20-50 lbs. ☐ 50-75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?

☒ No ☐ Yes -- (Check b, c, and d.)

5b. Simple grasping?

☐ Yes ☒ No

5c. Pushing and pulling?

☒ Yes ☐ No

5d. Fine manipulation?

☒ Yes ☐ No

6. Can the worker reach or work above the shoulder?

☒ Yes ☐ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement?

☒ Yes ☐ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle?

☒ Yes ☐ No

9. Are there cardiac, visual, or hearing limitations?

☒ No ☐ Yes -- (Describe)

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases?

☐ No

☒ Yes -- (Describe)

no exposure to extreme cold, dampness

11. Are interpersonal relations affected because of a neuropsychiatric condition?

☐ No ☒ Yes -- Describe (Ability to give and take supervision, meet deadlines, etc.)

12a. Can the individual work eight hours a day?

☒ Yes ☐ No -- (Indicate when)

12b. If not eight hours, how many and when?

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work?

☐ Yes

☒ No

14. Has the worker reached maximum improvement?

☒ Yes (Indicate when)

2/15/84

☐ No (Indicate when)

15. Remarks: (Restrictions from medication or other limitations)

The above restrictions are all occupational

16. Name

Douglas Fairbanks M.D.

17. Signature

18. Address

19. Telephone No.

20. Date

2/15/84

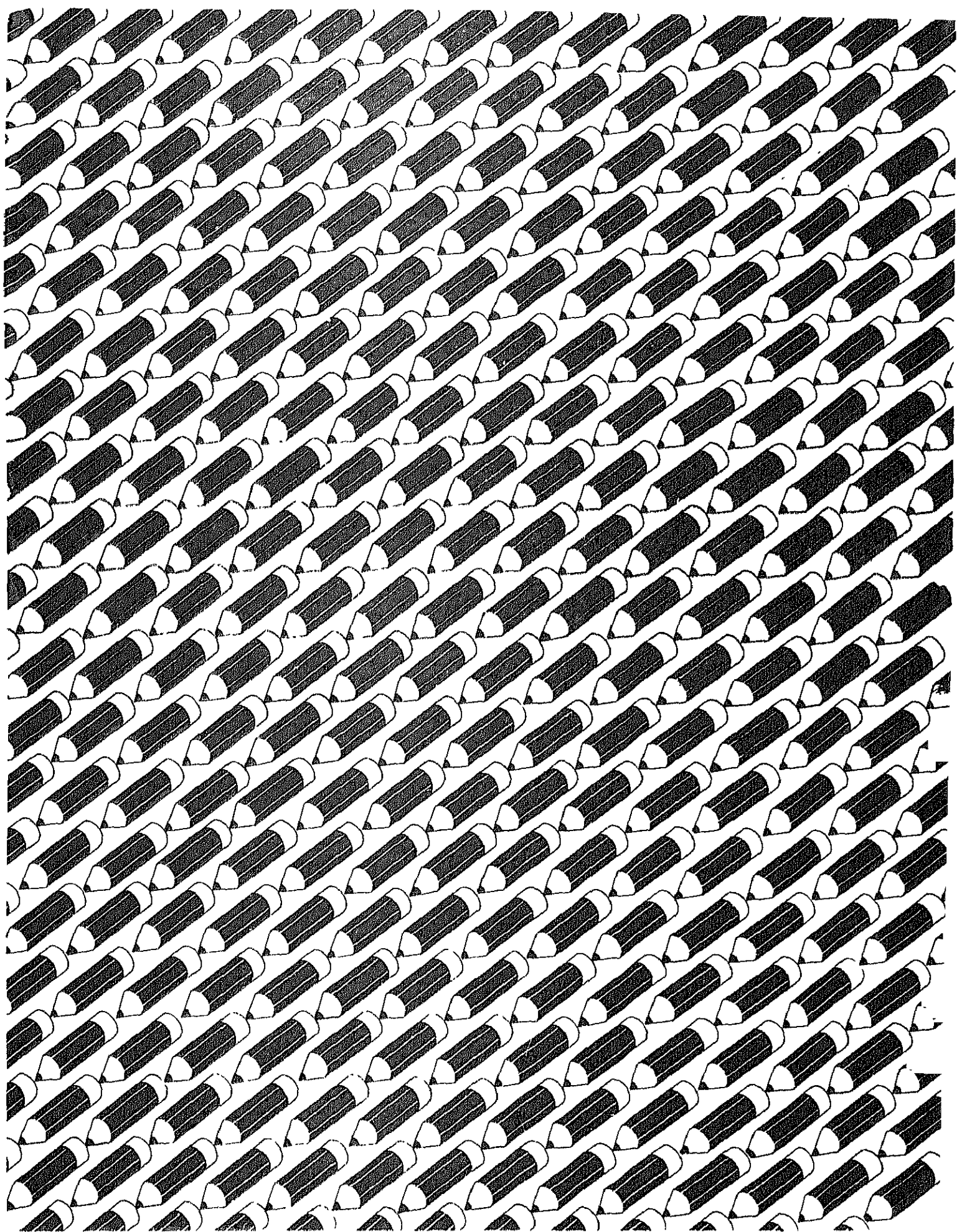
TASK BOOK
REHABILITATION
PERRY CASE
TASK 3

Taking into consideration work experience, education, physical and environmental factors and work restrictions, you have now identified a light duty assignment for Mr. Perry so he can return to gainful employment.

You are now going to make a job offer to the employee. You will have him come in to meet with you. After you have presented him with a formal written job offer, he informs you that he refuses to accept reemployment. What steps will you take with the claimant? Write your answers below.

AFTER YOU WRITE YOUR ANSWER, TURN TO PAGE 278 TO COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

CASE MATERIAL ENDS HERE



TASK BOOK
REHABILITATION
PERRY CASE
TASK 3

Answer:

1. Be sure that the claimant checks the refusal block on the job offer letter and signs it.
2. Inform him that this will be forwarded to OWCP and his compensation will probably be reduced or terminated.

TURN THE PAGE TO BEGIN A NEW CASE.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

You have reviewed your OWCP chargeback report and identified employees whose files you are going to review.

For the first five identified candidates you have obtained health unit records, official personnel folders, and the injury compensation claim files. After reviewing the records you prepared a fact sheet on each of the five candidates to include the following:

- . Job related disability
- . Work limitations
- . Concurrent disabilities
- . Current age
- . Employment history
- . Job skills
- . Length of time absent from work environment
- . Number of hours candidate is capable of working
- . Office of Personnel Management status
- . OWCP payroll status (LWEC or full benefit)
- . Previous limited duty accommodations.

Assume today's date is November 14, 1984.

Review the five fact sheets on the pages that follow (pages 280 - 284), then turn to page 285 for the task.

If you want to consult the resource information on rehabilitation, it may be found on pages 64 - 69 of the Resource Book.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

FACT SHEET

Mary R. Rubin Current Age: 66 years old

Monthly pay rate - \$1095.00

Date of Injury: 3/7/72. Compressed fractures of both knees as a result of a fall. Received Scheduled Award from OWCP for 60% permanent disability to both knees. Medical report dated 12/5/83 states employee could work four hours per day only in a completely sedentary assignment. Concurrent disabilities include hypertension.

Employment History: Ms. Rubin was a letter carrier for 32 years prior to her injury. There is no record of any disciplinary action in her personnel record. Did not return to work with the Postal Service after her injury. Retired on disability through OPM 6/11/74.

FACT SHEET

Joseph S. Watson Current Age: 54 years old

Monthly pay rate - \$1500.00

Date of Injury: 4/10/75. Ruptured disc as a result of lifting. Has had two lumbar laminectomies and a spinal fusion. Latest medical report from orthopedist Jerry Q. Pence, M.D. dated 4/5/83 states employee is permanently disabled for any type of work. Impartial Medical Evaluation has concurred and shown poor prognosis for ever returning to work. No concurrent disabilities.

Employment History: Mr. Watson worked for the Post Office as a Distribution Clerk for 25 years prior to his injury. No disciplinary action in his personnel records and he was the recipient of a Special Achievement Award. He never returned to any gainful USPS employment after the injury and eventually secured an approved disability retirement through OPM on 11/18/76.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

FACT SHEET

Alexander P. Hawkins Current Age: 46 years old

Monthly pay rate - \$1150.00

Date of Injury: 8/5/78. Amputation of the right arm.
Medical records dated 6/10/81 state employee is fit for limited duty eight hours per day. Only restrictions are in the area of lifting and climbing. Concurrent disabilities include multiple sclerosis diagnosed 9/15/83. Claimant is wheel-chair bound.

Employment History: Mr. Hawkins was a maintenance mechanic for seven years before his right arm was amputated in a conveyor belt accident. He was an excellent employee, the recipient of several adopted suggestion awards. He did not return to work after his injury and retired on disability through OPM on 3/9/80. Employee has AA degree in business administration.

FACT SHEET

Alice M. Washington Current Age: 33 years old

Monthly pay rate - \$1100.00

Date of Injury: 7/3/79. Ruptured lumbar disc. Refuses surgery. Medical report dated 1/9/84 states employee fit for limited duty eight hours per day. Can do no lifting, bending, squatting, climbing, kneeling or twisting. Generally needs sedentary work. No concurrent disabilities.

Employment History: Ms. Washington was hired as a Letter Carrier on 12/30/78. She was injured six months later and remained off work for approximately nine months. She returned to limited duty in 4/80 and worked in the assignment until it was terminated on 3/81. She was separated from the Postal Service in 3/82 due to her inability to perform the duties of Letter Carrier. As a result of physical disability, Ms. Washington was not eligible for disability retirement because she did not have 5 years Civil Service. Has a high school diploma and was a clerk typist for an insurance company for six years prior to her Postal Service employment.

FACT SHEET

William I. Elliott Current Age: 41 years old

Monthly pay rate - \$1300.00

Date of Injury: 9/10/78 - Ruptured lumbar disc as a result of a motor vehicle accident. Has had lumbar laminectomy and fusion. Can work eight hours per day in a completely sedentary assignment with no lifting. Cannot operate a motor vehicle. No concurrent disabilities.

Employment History: Mr. Elliott was a tractor trailer operator for nine years prior to his injury. Had attendance problems in the past with a suspension for two weeks. Has a high school diploma. Never returned to work after the injury. Retired on an approved disability through OPM on 2/5/80.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

Of the candidates whose records you have just reviewed, rank order them starting with #1 as the candidate most likely to result in a successful rehabilitation effort. Provide your rationale for each of your rankings. Write your answer below.

WHEN FINISHED, TURN TO PAGE 286 TO READ THE BOOK ANSWER.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

Answer:

There is no quantitative reason for the rank order, but the first three are clearly candidates more likely to be successfully rehabilitated. Consider your answer correct, as long as you have these three as likely to be successful:

- 1) Alice M. Washington - 33 years old. Fit for limited duty eight hours per day. Her disability can be accommodated since she worked limited duty after injury. She has no concurrent disabilities. Has only been absent from work environment for two years. Her typing skills enhance the ability to accommodate her. She is probably resentful over her previous separation from USPS.
- 2)* William I. Elliott - 41 years old. Fit for limited duty eight hours a day. He has no appreciable reemployment skills. He was a tractor-trailer operator and cannot drive a vehicle now. He has no concurrent disabilities. He has been absent from the work environment four years. Had some attendance problems. Has an approved disability retirement. Did not perform any limited duty after injury.
- 3)* Alexander P. Hawkins - 46 years old. He cannot go back to his maintenance mechanic job because of the loss of his arm. You would have to offer him a job that accommodates the arm loss. Since the multiple sclerosis was diagnosed subsequent to the on-the-job injury, it does not have to be accommodated. However, it is possible for him to do a sedentary job where the wheel chair doesn't matter. If the sedentary job would pay less than his former job, then OWCP would do an LWEC.

The following two candidates are less likely to be successfully rehabilitated:

- 4) Mary R. Rubin - 66 years old. Can only work four hours per day. You could offer her a 4 hour a day job and OWCP would then do an LWEC.
- 5) Joseph S. Watson - 54 years old. Permanently disabled. Medical report states that he is permanently disabled for any type of work.

TURN THE PAGE TO BEGIN A NEW CASE.

TASK BOOK
REHABILITATION
CASE 2
TASK 2

You have selected Alice M. Washington as your most viable rehabilitation candidate. You have a Work Restriction Evaluation from her treating physician and three possible job assignments.

Review the Work Restriction Evaluation from Dr. Alexander and the three job descriptions which follow on pages 288 - 291. Then turn to page 292 to do the task.

1. Injured workers' name (First, middle, last)

Alice M. Washington

2. OWCP No.

A25-105709

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY									
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8	
a. Sitting											✓	
b. Walking				✓								
c. Lifting			✓									
d. Bending			✓									
e. Squatting			✓									
f. Climbing			✓									
g. Kneeling			✓									
h. Twisting			✓									
i. Standing					✓							

4. Check the lifting restriction.

☒ 0-10 lbs. ☐ 10-20 lbs. ☐ 20-50 lbs. ☐ 50-75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?

☒ No ☐ Yes - (Check b, c, and d.)

5b. Simple grasping?

☐ Yes ☒ No

5c. Pushing and pulling?

☐ Yes ☒ No

5d. Fine manipulation?

☐ Yes ☒ No

6. Can the worker reach or work above the shoulder?

☐ Yes ☒ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement?

☒ Yes ☐ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle?

☒ Yes ☐ No *to and from work only!*

9. Are there cardiac, visual, or hearing limitations?

☒ No ☐ Yes - (Describe)

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases?

☐ No ☒ Yes - (Describe)

cannot work outside

11. Are interpersonal relations effected because of a neuropsychiatric condition?

☒ No ☐ Yes - Describe (Ability to give and take supervision, meet deadlines, etc.)

12a. Can the individual work eight hours a day?

☒ Yes ☐ No - (Indicate when)

12b. If not eight hours, how many and when?

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work?

☒ Yes ☐ No *Counseling to assist in adjustment to work environment*

14. Has the worker reached maximum improvement?

☒ Yes (Indicate when) *4/80* ☐ No (Indicate when)

15. Remarks: (Restrictions from medication or other limitations)

As long as patient refuses surgery, physical limitations will not improve.

16. Name

Raymond Y. Alexander

17. Signature

Raymond Y. Alexander

18. Address

*1409 Charles Street
Baltimore, MD 21206*

19. Telephone No.

645-9012

20. Date

3/8/84

TASK BOOK
REHABILITATION
CASE 2
TASK 2

JOB DESCRIPTION SUMMARY

SUPPLY CLERK

Requisitions and maintains supplies for a medium size postal facility. Required to load and unload supply crates weighing 50 pounds. Types supply requisitions. Performs inventory functions. Must be able to type 40 words per minute and use standard office equipment such as an adding and xerox machine.

JOB DESCRIPTION SUMMARY

WINDOW CLERK

Sells postal products to customers. Is required to stand eight hours per day at the counter in the post office lobby. Must accept packages to be mailed over the counter weighing up to 70 pounds. Lifting above shoulder level is required. When lobby is not busy, employee is required to manually file mail.

TASK BOOK
REHABILITATION
CASE 2
TASK 2

JOB DESCRIPTION SUMMARY

SAFETY INSPECTOR

Conducts on-site safety inspections of postal facilities. Well developed communication skills required. In inspecting physical facilities, incumbent is required to climb ladders and steps, required to bend and twist. Must provide own transportation to facility sites.

TASK BOOK
REHABILITATION
CASE 2
TASK 2

These three positions are the only three jobs available.
Currently there are no completely sedentary jobs available.

Select the position that best meets Ms. Washington's physical capabilities and which requires the least amount of modification. Circle your answer below.

- a. Supply clerk. Turn to page 328, Box 4.
- b. Window clerk. Turn to page 300, Box 3.
- c. Safety inspector. Turn to page 301, Box 4.

TASK BOOK
REHABILITATION
CASE 2
TASK 3

You have decided the position of supply clerk requires the least amount of modification and best meets Ms. Washington's physical capabilities.

Read the following job description for supply clerk on page 294. Then turn to page 295 and do the task.

JOB DESCRIPTION

Position Title: Supply Clerk
Position Number: KP-8
Level: PS-5
Occupational Code: 2315-04

Functional Purpose: Requisitions and maintains supplies for a postal facility.

Organizational Relationships: Reports to Supply Supervisor

Job Duties:

1. Type and xerox supply requisitions
2. Perform on-site inventory functions, moving boxes of inventory to assigned locations. Review detached units inventory reports comparing stated supplies and equipment with their authorization
3. Occasionally loads and unloads supply crates weighing 50 pounds.
4. Accepts emergency telephone supply orders and types the requisition.

Proficiency Requirements:

1. Ability to type 40 words per minute
2. Ability to use standard office equipment such as an adding and xerox machine.

Environmental Factors: Clerical duties will be performed using a standard office desk and executive chair. The chair will have arm and back rests and will swivel.

Physical Requirements: This position requires that the employee be able to stand up to four hours per day, five days per week and walk to and from the worksite. The position requires occasional lifting of crates weighing up to 50 lbs. On-site inventory functions require repetitive movements such as bending, reaching, twisting, or squatting.

The position of supply clerk now needs to be modified to meet Ms. Washington's physical limitations. For the section on Job Duties below, select the item which best describes the modifications required, then turn to the page indicated next to your selection.

"Job Duties

1. Type and xerox supply requisitions.
 2. Perform on-site inventory functions, moving boxes of inventory to assigned locations.
Review detached units inventory reports comparing stated supplies and equipment with their authorization.
 3. Occasionally loads and unloads supply crates weighing 50 pounds.
 4. Accepts emergency telephone supply orders and types the requisition."
- a. Duty 1: Employee will xerox supply requisitions not to exceed two hours standing a day.
Duty 2: Eliminate "moving boxes of inventory".
Duty 3: Employee will not be required to load or unload supply crates.
Duty 4: O.k. as is.
Turn to page 333 Box 2.
- b. Duties 1 and 4 are acceptable.
Duty 2: Eliminate "moving boxes of inventory".
Duty 3: Employee will not be required to load or unload supply crates.
Turn to page 330, Box 1.
- c. Duties 1 and 4 are acceptable.
Duty 2: Eliminate "moving boxes of inventory".
Duty 3: Employee will not be required to load or unload supply crates weighing 10 lbs or more.
Turn to page 332, Box 2.
- d. Duty 1: Acceptable
Duty 2: Qualify "moving boxes" by adding not to exceed 10 lbs.
Duty 3: Eliminate
Duty 4: Eliminate requirement to answer the telephone.
Turn to page 331, box 3.

The physical requirements of the job as stated below must also be modified.

"Physical Requirements: This position requires that the employee be able to stand up to four hours per day, five days per week and walk to and from the worksite. The position requires occasional lifting of crates weighing two to 50 lbs. On-site inventory functions require repetitive movements such as bending, reaching, twisting, or squatting".

Select the re-statement of the physical requirements below that best fits her limitations. Then turn to the page indicated to check your answer.

- a. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day.
 . Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling, operating any type of motor vehicle, or reaching above the shoulders.
 Turn to Page 331, Box 2.

- b. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day and walk not to exceed 1 hour per day.
 . Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling, or reaching above the shoulders.
 Turn to Page 333, Box 1.

- c. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day.
 . Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling.
 Turn to Page 330, Box 2.

- d. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day and walk not to exceed 1 hour per day.
 . Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling, operating any type of motor vehicle, or reaching above the shoulders.
 Turn to Page 332, Box 3.

TASK BOOK
REHABILITATION
CASE 2
TASK 5

When Ms. Washington was injured she was a Grade 5, Step 1. In 3/81 she began filing claims with OWCP because she was in an LWOP status as a result of her limited duty assignment being terminated. She was eligible for a recurrent rate because it had been more than six months since her first return to duty. Consequently, when she returned to limited duty her rate was a Grade 5 Step 2. While in a leave-without-pay status on OWCP rolls, Ms. Washington did earn one additional step increase, making her a Grade 5 Step 3 at the time of her separation.

During your reemployment interview, Ms. Washington poses the following question. What answer would you give her? Select the best answer to the following questions below.

(If you want to refer to the Resource Book, consult pages 70 - 75.)

"Suppose I accept your job offer and then am unable to continue working as a result of my accepted low back condition. What are my options?"

- a. Your doctor has certified that the available job is within your work limitations and that you are capable of performing these duties. Turn to Page 331, Box 1.
- b. If you find yourself unable to continue working because of your work injury you should probably apply for disability retirement. Turn to Page 333, Box 4.
- c. If you are unable to continue working because of your back injury, you can obtain a new work restriction evaluation from the treating physician. Turn to Page 330, Box 3.
- d. If you are unable to continue working because of your back injury, you should request a LWEC rating from OWCP. Turn to Page 332, Box 1.

TASK BOOK
REHABILITATION
CASE 2
TASK 6

Ms. Washington has a second question:

"When I was terminated from the Postal Service in March 1982, I was a Grade 5 Step 3, yet I am returning as a Grade 5 Step 2. Why?"

Which of the responses below is correct?

- a. The salary is determined for former employees by the grade and step in effect at the time of injury or recurrent disability. Ms. Washington will be paid at her current rate for a Grade 5 Step 2 since this was the rate in effect on 3/81 at the time of recurrence. Turn to Page 330, Box 4.
- b. The salary is determined for former employees by the grade at which the current job is classified. If that is less than the employee's former salary, the difference will be made up by compensation payments (LWEC). Turn to Page 333, Box 3.
- c. The salary is determined for former employees by the grade and step the employee would be in if they had not received compensation. So, if Ms. Washington would have earned two step increases, she will return to a Grade 5 Step 4. Turn to Page 331, Box 4.

TASK BOOK
REHABILITATION
CASE 2
TASK 7

Ms. Washington has a final question: "What happens if I decline your job offer? Select the best answer below.

- a. You will no longer be entitled to workers compensation. However you would still qualify for disability retirement from OPM. Turn to page 334, Box 1.
- b. You will be asked to sign the declination of employment and state your reasons. The Employing Agency will notify OWCP of the job offer and the declination. If OWCP considers the position to be within the employee's physical capabilities, then compensation benefits will be terminated or reduced. Turn to Page 332, Box 4.
- c. If you feel that the job being offered you is less desirable than your previous job, you may decline. However, you must agree to enter a vocational rehabilitation program to qualify for a job equivalent to your former one. Turn to page 334, Box 3.

1

No. Even though you do want the opinion of a third doctor to resolve the dispute, the employing agency cannot require the claimant to undergo another exam.

Return to page 254 for a different answer.

2

This is not the best answer because there has been a recent change in the status of disability.

Return to page 272 for another choice.

3

Ms. Washington could possibly be accommodated in the window clerk position if she were allowed to sit rather than stand at the window. The lifting requirement would need to be waived and manual distribution of mail above shoulder level is outside her limitations. Further research would have to be done to determine if there is eight hours work available in the unit without lifting or filing mail above shoulder level.

There is a better choice. Return to page 292 and select again.

4

Correct. Your light duty job must accommodate any conditions pre-existing the injury and those conditions resulting from the injury. Personal health conditions that arose later are not accommodated.

Turn to page 275 for the following task.

1

This is partially correct. However, you need not accommodate any work restrictions that are "personal" or "concurrent".

Return to page 274 and choose a better answer.

2

This is perhaps the case, but you have more certain grounds on which to question continued compensation.

Return to page 272 for a different choice.

3

No. Even though one doctor offers only subjective findings and the other doctor presents objective findings, they are in conflict over whether or not the claimant is totally disabled. The conflict must be resolved first.

Return to page 254 for another choice.

4

The position of safety specialist does not meet Ms. Washington's physical capabilities in that the assignment requires bending, climbing, twisting and all other physical activities required of an inspector. Also, the employee must provide transportation to the facility sites. It would not be cost effective for the employing agency to drive Ms. Washington to the job sites.

Return to page 292 and select again.

TASK BOOK
REHABILITATION
JOHNSON CASE
TASK 1

Refer back to the Resource Book, pages 58 - 63, then do the following case.

Mr. Johnson injured his low back on 11/1/82 when he lifted a package weighing approximately 25 pounds from the floor to a handtruck. Mr. Johnson was treated by his family doctor, Jack Samuels, M.D., who considered him fit for limited duty and referred him to an orthopedic specialist. Orthopedist William X. Roseborough has seen Mr. Johnson on a monthly basis since 11/10/82 and continues to find him fit for limited duty. The last three CA-17's including the latest from Dr. Roseborough, dated 5/10/83 have been identical with only the examination date changing.

Review the following CA-1 and attending physician's reports from Doctors Samuels and Roseborough which follow on pages 303 - 310. Then turn to page 311 to do the task.

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) Johnson, George E		2. Date of Birth 2-11-61	3. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		4. Social Security Number 016-58-3422	
5. Employee's Home Mailing Address (No., street, city, state, zip code) 709 Bethlehem Rd Parkton, Md 20819		6. Home Telephone Area Code: 301 Number: 207-1843	
7. Name and Address of Employing Agency U S Postal Service 1700 E Fayette Street Baltimore, Md 21233-9408		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) Fayette Street Station workfloor	
9. Date and Hour of Injury (mo., day, year) <input checked="" type="checkbox"/> AM 11/1/82 7:15 <input type="checkbox"/> PM	10. Date of This Notice (mo., day, year) 11/2/82	11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation Letter Carrier
13. Cause of Injury (Describe how and why the injury occurred) Lifting a package weighing approximately 25 pounds from the floor to a handtruck.		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) Pain in my low back	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.			
16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input checked="" type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).			
<p style="text-align: center;">George E Johnson</p> <p style="text-align: center;">_____ Signature of Employee or Person Acting on His/Her Behalf</p>			
17. Statement of Witness (Describe what you saw, heard or know about this injury) I saw carrier Johnson lift the package, drop it on to the handtruck and then grab his back. He appeared to be in pain.			
18. Witness' Signature Mary E Carter	19. Witness' Address 908 Washington St. Baltimore Md 21229	20. Date Signed (mo., day, year) 11/2/82	

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency <i>U.S. Postal Service</i>		22. Bureau or Office <i>Fayette Street Station</i>	
23. Name and Address of Reporting Office (No., street, city, state, Zip Code) <i>1900 E Fayette Street Baltimore, Maryland 21233</i>			
24. Regular Work Day Begins <i>6:00</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends <i>2:30</i> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		25. Number of Hours Worked Per Day <i>8</i>	26. Circle Days Paid Per Week S <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> S
27. Date and Hour of Injury (mo., day, year) <i>11/1/82 7:15</i> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) <i>11/1/82 (Yetal)</i>	29. Date and Hour Stopped Work (mo., day, year) <i>DID NOT STOP</i>	30. If Pay Has Been Terminated, Give Date (mo., day, year) <i>N/A</i>
31. 45 Day Period Begins (mo., day, year) <i>N/A</i>	32. Pay Rate When Employee Stopped Work <i>\$24,040 per yr.</i>	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM <i>DID NOT STOP</i>	34. Name of Supervisor at Time of Injury <i>Ralph Jones</i>
35. Was Employee in Performance of Duty At The Time of Injury? <input checked="" type="checkbox"/> Yes, <input type="checkbox"/> No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.			
36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Detailed Report.			
37. Was Injury Caused By Third Party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Furnish Name and Address of Party Responsible.			
38. Date Employee First Obtained Medical Care for the Injury (mo., day, year) <i>11/1/82</i>	39. Name and Address of Physician First Providing Medical Care <i>Jack Samuels, M.D. 1411 Somner Road Kingville, Md 21128</i>		40. Do Medical Reports Show Employee is Disabled For Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. If No, Furnish A Detailed Explanation.			
42. Does The Employing Agency Controvert Continuation of Pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No. If Yes, Give Full Explanation for Basis of Controversy (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated. Attach Additional Sheets if More Space is Needed.			
43. Filing Instructions <input type="checkbox"/> No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder <input checked="" type="checkbox"/> Medical Expense Incurred or Expected. Forward this Form to OWCP <input type="checkbox"/> Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP			
44. All information requested on this Form has been furnished. If Not, it will be submitted by _____ (Fill in Date)			
45. Signature of Supervisor <i>Ralph Jones</i>	46. Title and Office Phone Number <i>Supar. 922-1315</i>		47. Date (mo., day, year) <i>11/3/82</i>

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A - AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Jack Samuels, M.D.
1411 Sumner Rd
Kingville, Md. 21118

2. EMPLOYEE'S NAME (Last, first, middle)

Johnson, George E.

3. DATE OF INJURY
(mo., day, year)

11/1/82

4. OCCUPATION

Letter Carrier

5. DESCRIPTION OF INJURY OR DISEASE

low back pain as a result of lifting a 25
pound package from the floor to a
handtruck

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

- ☒ A. FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.
- ☐ B. THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDER-SIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)

Ralph Jones

9. TITLE

Supervisor, Delivery

10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER

922-1315

11. DATE (mo., day, year)

11/1/82

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address)

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.

Dept. or Agency U.S. Postal Service
Bureau or Office Fayette Street Station
Local Address 1900 E. Fayette St
(Including Zip Code) Balto Md. 21233

PART B - ATTENDING PHYSICIAN'S REPORT						
14. EMPLOYEE'S NAME (Last, first, middle) <i>George E Johnson</i>						
15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU? <i>Lifting 25 pound package felt a pain in my low back</i>						
16. IS THERE ANY HISTORY OR EVIDENCE OF PRE EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)						
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
17. WHAT ARE YOUR FINDINGS (include results of x rays, laboratory tests, etc.)?				18. WHAT IS YOUR DIAGNOSIS?		
<i>tenderness right low back area</i>				<i>acute lumbosacral strain</i>		
19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)						
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
20. DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, date of admission (mo., day, year) Date of discharge (mo., day, year)				21. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
22. SURGERY (if any, describe type)				23. DATE SURGERY PERFORMED (mo., day, year)		
24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? <i>Initial evaluation and referral to an orthopedic specialist</i>				25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?		
26. DATE OF FIRST EXAMINATION (mo., day, year) <i>11/1/82</i>		27. DATE(S) OF TREATMENT (mo., day, year) <i>11/1/82 only</i>		28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year) <i>referred 11/1/82</i>		
29. PERIOD OF DISABILITY (if termination date unknown, so indicate) (mo., day, year) TOTAL DISABILITY: FROM _____ TO _____ PARTIAL DISABILITY: FROM <i>11/1/82</i> TO <i>unknown</i>				30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year) LIGHT WORK REGULAR WORK		
31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FURNISH DATE ADVISED (month, day, year) <i>11/1/82</i>						
32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS. <i>Sedentary work only No lifting until evaluation by orthopedist</i>						
33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED. <i>Orthopedic referral</i>						
34. DO YOU SPECIALIZE? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (if yes, state specialty) <i>FAMILY Practice</i>						
35. SIGNATURE OF PHYSICIAN <i>Jack Samuels, M.D.</i>		36. ADDRESS (Number, street, city, state, zip code) <i>1411 Somner Road Kingsville, Md. 21128</i>		37. PHYSICIAN'S SOCIAL SECURITY NUMBER <i>107-15-1111</i>		
				38. DATE OF REPORT (mo., day, year) <i>11/2/82</i>		
39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.						
Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price		Amount	
			Cost	Per	\$	c
		TOTAL				

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A - SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

William X Roseborough, M.D.
811 Park Heights Avenue
BALTIMORE, MD 21209

2. EMPLOYEE'S NAME (Last, first, middle)

Johnson, George E

3. DATE OF INJURY
(Mo., day, year)

11/1/82

4. OCCUPATION

Letter Carrier

5. SOCIAL SECURITY NUMBER

016-58-3422

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

low back pain as a result of lifting a 25 pound package from the floor to a handtruck

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD 5 hours NOISE _____ DUST _____
FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

SEDENTARY - LIFTING 0 to 10 POUNDS
LIGHT - LIFTING 10 to 20 POUNDS
MODERATE - LIFTING 20 to 50 POUNDS
HEAVY - LIFTING 50 to 100 POUNDS
PULLING/PUSHING, CARRYING
REACHING OR WORKING ABOVE SHOULDER
WALKING (HOURS)
STANDING (HOURS)
SITTING (HOURS)
STOOPING (HOURS)
KNEELING (HOURS)
REPEATED BENDING (HOURS)
CLIMBING (HOURS)
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.
OTHER:

LITTLE OR NONE	MODERATE	OFTEN
		3 hours
0		5
		3
		5
		3
0		
0		
0		
0		
1		
1		

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

US Postal Service
Fayette Street Station
1900 East Fayette St
Baltimore, Md. 21233

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

[illegible]

TASK BOOK
REHABILITATION
JOHNSON CASE
TASK 1

Assume today's date is May 20, 1983. Mr. Johnson is still on the agency's rolls. Every six months, it is your policy to review all temporary limited duty assignments. Select the choice below which best describes the action you would take at the conclusion of your review:

- a. Continue the assignment until your next review. Turn to page 327, Box 2.
- b. Require additional medical evidence from the treating physician to support the continuing need for limited duty. Turn to page 326, Box 4.
- c. Request OWCP to do an LWEC. Turn to page 329, Box 2.
- d. Get another medical opinion through a fitness for duty. Turn to page 328, Box 3.

If you wish to consult the Resource, refer to pages 59 - 63.

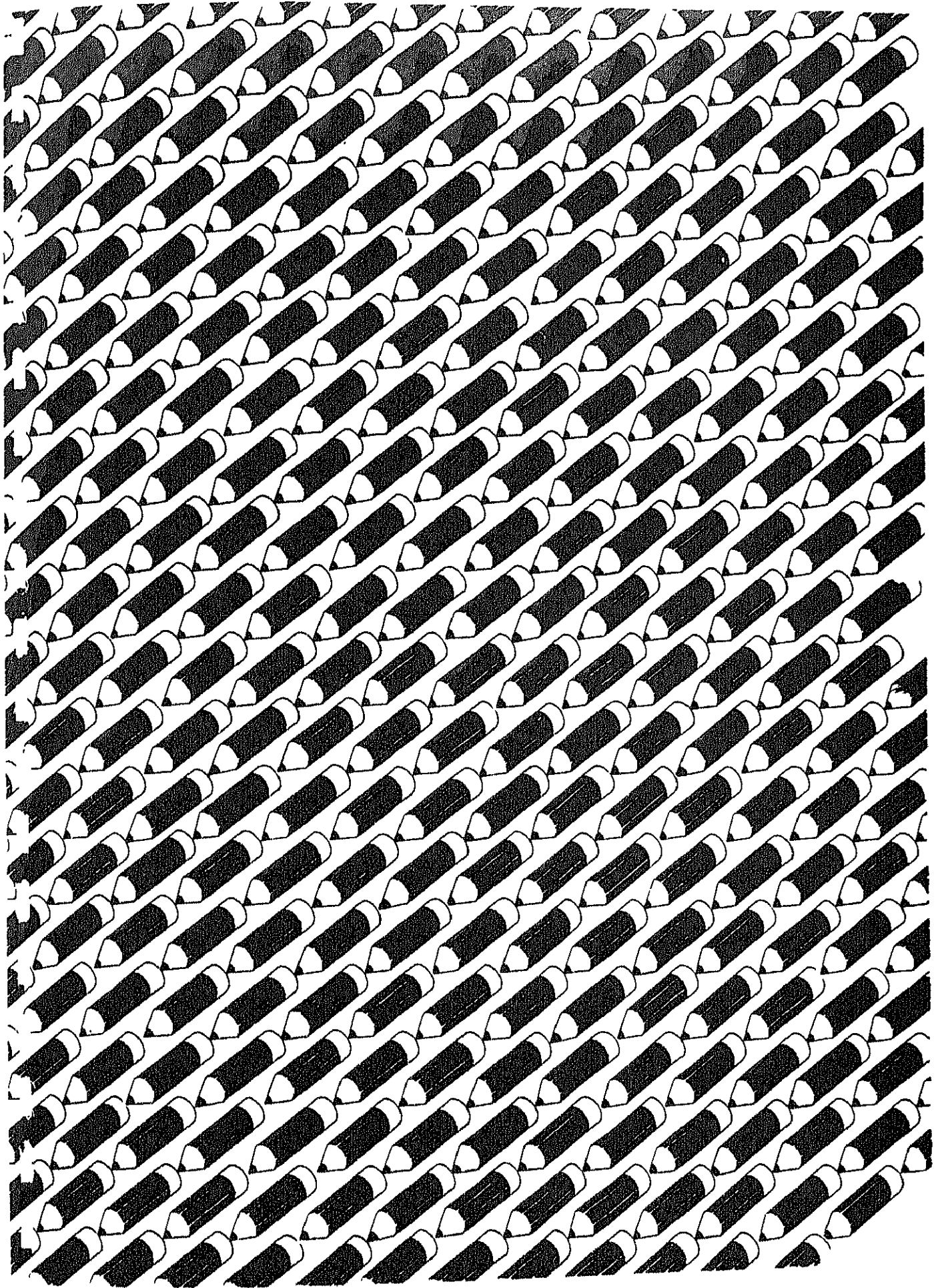
TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 2

Your limited duty review reveals that additional medical evidence is needed from the treating physician. You will have to prepare a letter requesting the required information to make a determination on Mr. Johnson's need for continuing limited duty. For this task, list below the information you would request from the physician.

If you want to refer to the Resource, the material covering this area can be found on pages 65 - 66 in the Resource.

WHEN YOU HAVE FINISHED, TURN TO PAGE 313 TO COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

END OF TASK MATERIAL



TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 2

Answer:

You would request from the physician:

- 1) Objective findings which prevent return to the work assignment,
- 2) Prognosis for the employee's return to his regular assignment,
- 3) If the employee has limitations which preclude him from returning to full duty, the physician should:
 - a. Identify them and
 - b. Establish, through rationalized medical evidence, a causal relationship between the continuing physical limitations and the job-related injury.

TURN THE PAGE TO SEE AN EXAMPLE OF A LETTER YOU MIGHT WRITE.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 2

Answer (continued): Your letter might look like this:

May 20, 1983

William X. Roseborough, M.D.
811 Park Heights Avenue
Baltimore, MD 21209

Dear Dr. Roseborough:

This will refer to the medical care you are providing our employee, George E. Johnson who was injured on 11-1-82.

As you know, Mr. Johnson sustained an injury to his low back six months ago when he bent down to lift a parcel. He has worked in a limited duty assignment since 11/1/82 with no change in his physical restrictions. Your reports continue to indicate that Mr. Johnson cannot lift in excess of 20 pounds. Since limited duty is designed to be temporary in nature, it is essential that we determine the extent and duration of Mr. Johnson's physical limitations.

Mr. Johnson's regular assignment is that of a letter carrier. This requires him to lift a maximum of 35 pounds, engage in prolonged walking/standing, reach above the shoulders for approximately three hours and do a moderate amount of climbing and bending. He is required to work eight hours five days per week with occasional overtime.

1. Please advise in your medical opinion when Mr. Johnson will be able to return to this assignment and the approximate date.
2. If Mr. Johnson cannot return to his regular assignment, please provide us with a detailed medical report including:
 - a. Objective findings which prevent his return to the regular work assignment.
 - b. A reasoned medical opinion that connects his current physical limitations to the job-related injury.
 - c. His physical limitations and their expected duration.

I appreciate your efforts in assisting us to accommodate Mr. Johnson and have enclosed a self-addressed envelope for your reply.

Sincerely,

John S. Lilly
Injury Compensation Supervisor

cc: OWCP District Office

TURN THE PAGE.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 3

Review Dr. Roseborough's response to your request for medical information on the following page. Then turn to page 317 and answer the questions.

William X. Roseborough, M.D.
Orthopedic Specialist
811 Park Heights Avenue
Baltimore, MD 21209
June 10, 1983

Mr. John S. Lilly
Injury Compensation Supervisor
U. S. Postal Service
1900 E. Fayette Street
Baltimore, MD 21233-9408

Dear Mr. Lilly:

Thank you for your recent letter concerning your employee and my patient, George A. Johnson.

It is unfortunate that I cannot provide you with the straightforward information you require. Both myself and Mr. Johnson had expected a return to his letter carrier position by now. His low back strain has not responded to conservative treatment, yet objective findings do not warrant more aggressive medical care.

In view of the above, it is recommended that Mr. Johnson continue in his limited duty assignment for another three months. His physical limitations are no lifting over 20 pounds and my diagnosis remains resolving low back strain. I will reevaluate Mr. Johnson in three months for a possible return to full duty.

William X. Roseborough, M.D.
Orthopedic Specialist

TURN THE PAGE.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 3

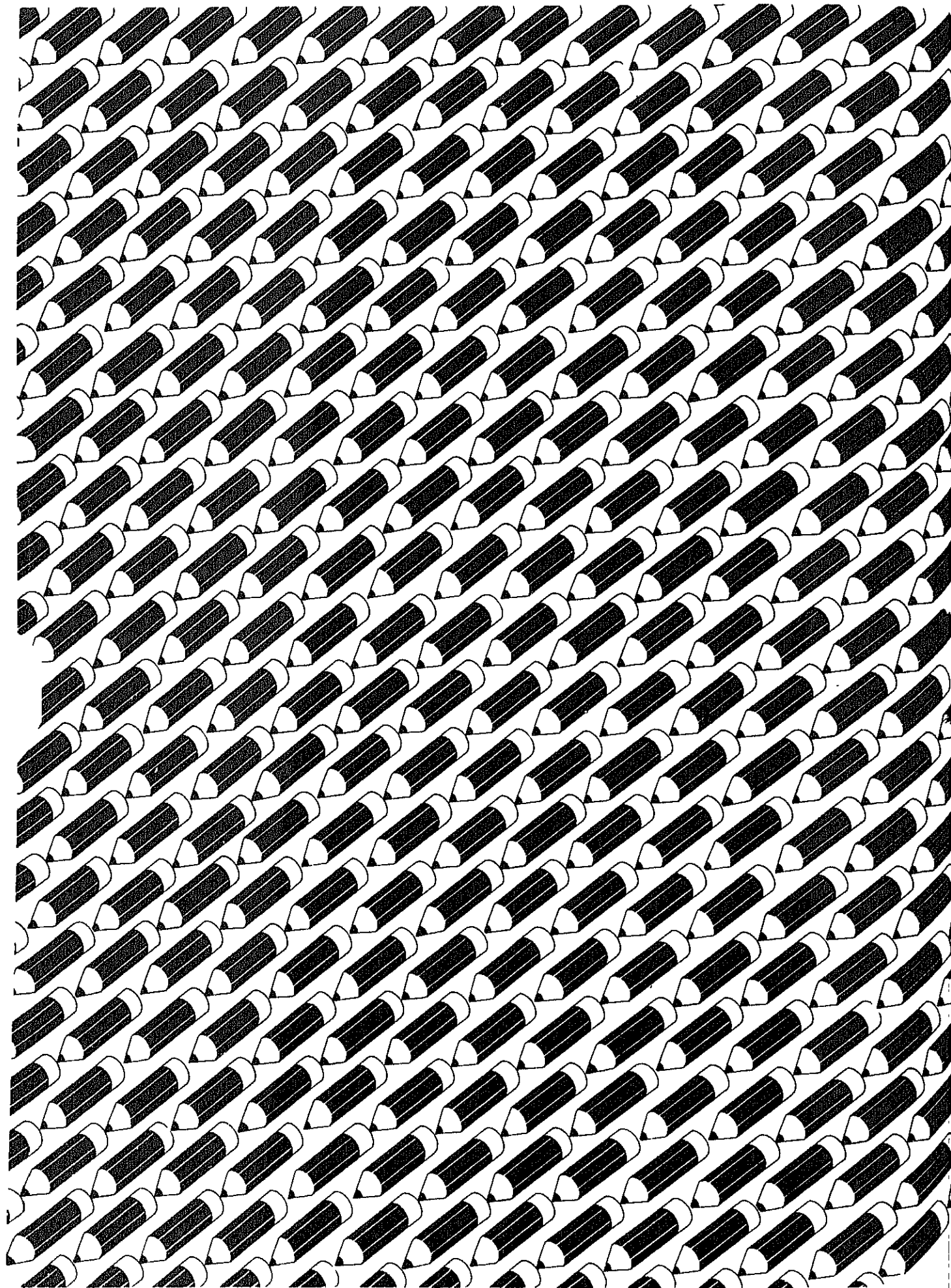
Write your answers to the following questions below.

- a) Does the medical report contain the information you need to make a decision?
- b) If not, list the specific points that are missing.

If you want to consult the Resource Book, turn to pages 59 - 63.

WHEN YOU HAVE FINISHED, GO TO PAGE 318 TO CHECK YOUR ANSWER.

END OF TASK MATERIAL



TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 3

Answer:

- a) The medical report does not contain the information needed to make a decision.
- b) The following are missing from the report:
 - 1) Detailed objective findings.
 - 2) Reasoned medical opinion establishing a relationship between the physical restrictions and the job-related injury.

GO ON TO THE NEXT TASK.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 4

Select the best course of action from the choices below. Then turn to the page indicated next to your selection to check your answer.

- a. Continue Mr. Johnson in the limited duty assignment pending the next medical reevaluation. Turn to page 328, Box 2.
- b. Request that OWCP get a second opinion on Mr. Johnson. Turn to page 327, Box 1.
- c. Require Mr. Johnson to take a Fitness for Duty medical exam. Turn to page 329, Box 3.

If you want to review the Resource, refer back to pages 59 - 63.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 5

Your Installation Head has approved the scheduling of a Fitness for Duty examination on George E. Johnson. You have selected Board Certified Orthopedic Specialist Joseph R. Holmes to conduct the examination. You have provided Dr. Holmes with job descriptions for Mr. Johnson's regular and limited duty assignments, a copy of the original injury report, as well as all medical reports pertaining to the injury. You have requested that Dr. Holmes do a one time medical evaluation of Mr. Johnson's low back condition and that he specifically address the issues of fitness for duty, objective physical findings and their relationship to the injury, and the extent and duration of any physical restrictions stemming from this injury.

Dr. Holmes conducted his examination and provided you with his report on pages 321 and 322. Review his findings and decide your next course of action.

Then go to page 323 to choose your answer.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 5

July 30, 1983

Mr. John S. Lilly
Injury Compensation Supervisor
U. S. Postal Service
1900 E. Fayette St.
Baltimore, MD 21233-9408

Dear Mr. Lilly:

After reviewing all the information provided me, a Fitness for Duty examination was performed on George E. Johnson on 7/19/83 in regard to his low back condition.

General health was good and general physical examination was within normal limits.

Mr. Johnson is a 22 year old white male with no history of orthopedic problems until he injured his low back on 11/1/82 lifting a 25 pound package. He was treated by his family doctor Jack Samuels, M.D. who referred him to orthopedist William X. Roseborough, M.D. Mr. Johnson does not remember if Dr. Roseborough took X-rays of his back but he does remember going to physical therapy. Mr. Johnson has worked limited duty since his injury.

Subjective complaints from Mr. Johnson include pain on rising, pain when he bends to lift, and general "achiness" at the end of the work day. Mr. Johnson also stated that he is becoming very depressed about his physical condition and is considering changing doctors to a chiropractor.

Examination:

In the supine position (on his back) the employee had no complaints of pain. Straight leg raising, both right and left legs separately and both legs together caused no low back pain and he was able to elevate his legs to the full extent. The deep tendon reflexes at the knees and ankles were normal, both without and with reinforcement. Range of motion of the entire back was performed normally and to the full extent without any

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 5

-2

complaints of pain. He was able to move his back easily in all directions. Heel/toe stand/walk was normal without complaints. Deep squatting was performed normally without complaints. There was no tenderness of the backbones or back muscles to palpation or to percussion. There was no sensory loss. Babinski reflex was normal bilaterally (stimulating the soles of the foot). Muscle strength and tone of the back muscles and leg muscles were normal. There were no muscle spasms of the back.

The only abnormal finding was mildly poor posture; kyphosis (round shouldered) and lordosis (sway back). X-rays normal lumbar spine.

Impression:

Normal musculoskeletal and neurologic exam, with the exception of mildly poor posture, round shouldered and sway backed.

Duty status:

After reviewing the job description for Letter Carrier, it is my opinion that Mr. Johnson could perform all the physical requirements of the position including the requirement to lift 35 pounds. He has no physical restrictions as a result of his 11/1/82 low back injury.

Joseph A. Holmes, M. D.
Orthopedic Specialist

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 5

Which course of action should you now take? Select one decision below.

- a. There is a conflict of medical opinion. Request OWCP to order an impartial medical exam to resolve the conflict. The claimant stays on light duty until the conflict is resolved. Turn to page 326, Box 2.
- b. There is a conflict of medical opinion. Resolve it by scheduling the claimant to see a third doctor to resolve the conflict. The claimant must stay on light duty meanwhile. Turn to page 328, Box 1.
- c. The objective findings of Dr. Holmes take precedence over the subjective opinion of the treating physician. Mr. Johnson may now be returned to regular duty. Turn to page 327, Box 4.
- d. There is an unresolved difference of medical opinion. Ask OWCP for an impartial exam. Due to Dr. Holmes' clearance for regular duty, you may reassign the claimant to regular duty. Turn to page 329, Box 1.

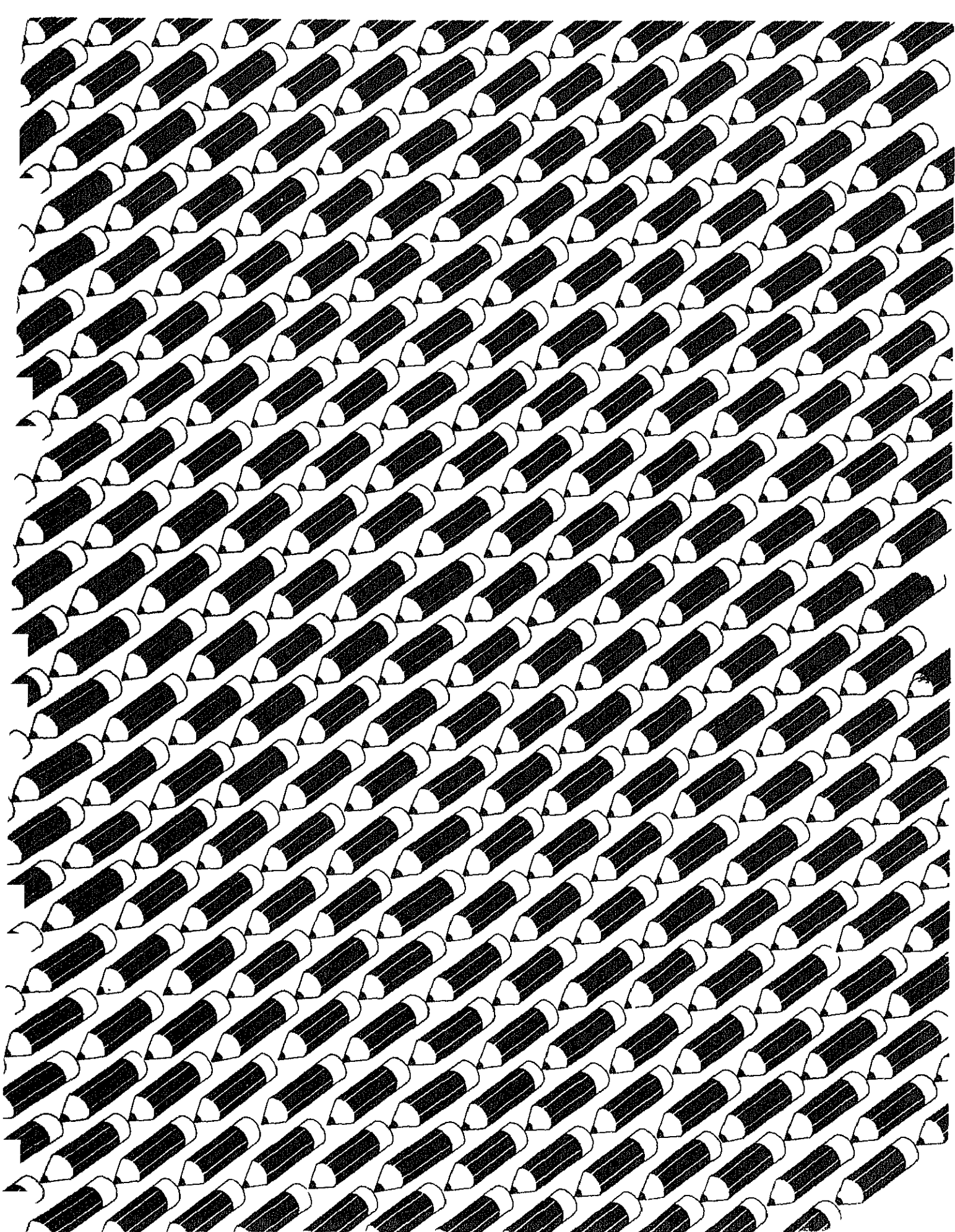
TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 6

In a letter to OWCP forwarding Dr. Holmes' evaluation, list the points you will make that support your requesting a final determination on the employee's physical limitations and duty status.

If you wish to review resource material, consult pages 59 - 63 of the Resource Book.

TURN TO PAGE 325 TO CHECK YOUR ANSWER.

END OF TASK MATERIAL



TASK BOOK
REHABILITATION
JOHNSON CASE
TASK 6

Answer:

It should include the following points:

1. Orthopedist William X. Roseborough, M.D. has been treating Mr. Johnson for the past eight months. The treatment has been conservative, has included physical therapy, and now consists of evaluations every three months. We receive a CA-17 on the occasion of each evaluation. However, they are extremely general and there has been no change in the diagnosis or physical restrictions for the past three evaluations.
2. Attempts to get more definitive information from Dr. Roseborough have been unsuccessful. His latest medical report dated 6/10/83 merely reiterates that the employee should remain on limited duty for another three months with a lifting restriction of 20 pounds.
3. In view of the above, Mr. Johnson was scheduled for a Fitness for Duty examination by Board Certified Orthopedic Specialist Joseph R. Holmes on 7/19/83. Dr. Holmes' findings included normal X-rays of the lumbar spine, normal musculoskeletal and neurologic examination and that the employee has no residual physical disability as a result of his 11/1/82 job-related injury. He further found that the employee was fully capable of performing all of the duties of a Letter Carrier with no restriction as to physical ability.
4. Postal policy requires that when an employee is unable to perform all the duties of their regular assignment, they must be placed on temporary limited duty. Mr. Johnson has worked a limited duty assignment since 11/1/82 because of his inability to lift the required 35 pounds. Inasmuch as there is now conflicting medical opinion as to his physical limitations and their cause, it is requested that he be referred to an impartial specialist for final resolution of these conflicts.

THIS IS THE END OF THE CASE MATERIAL. GO TO PAGE 335 TO DO A NEW EXERCISE.

1

There is a concurrent condition, but the medical report does not indicate how much this contributes to his current disability. There is a better basis to question the continued compensation.

Return to page 272 and choose again.

2

Correct. OWCP must resolve the conflict. Meanwhile you cannot ignore work restrictions imposed by the treating physician.

Turn to page 324 for the next task.

3

This is a direct course of action, but you cannot require an FFD for someone who is no longer on the agency rolls.

Return to page 274 and try again.

4

This is correct. There are no reasons given for why a back sprain would incapacitate a young man this long (6 months).

Turn to page 312 for the next task.

1

This is a possible course of action. However, there is a more direct way to handle the problem.

Return to page 319 for another choice.

2

There does not seem to be any point in delaying action at this point. A back sprain will normally resolve itself in 6-8 weeks. It has been 6 months, and there has been little change.

Return to page 311 and make a different selection.

3

This is partially correct. However, you may have to accommodate other work limitations in this case.

Return to page 274 and choose again.

4

No. Until the conflict is resolved, you cannot violate work restrictions imposed by the treating physician.

Return to page 323 for another choice.

1

No. You do not have authority to resolve a conflict in medical opinion.

Return to page 323 for another choice.

2

This would put off the decision for another 3 months. Since it is already 6 months since the injury, it is time to take a more active role.

Return to page 319 for another choice.

3

It might eventually be necessary to do this in order to get the information you need. However, there is something simpler you can do.

Return to page 311 and choose again.

4

Correct. The position of supply clerk would appear to best meet Ms. Washington's physical restrictions and require the least amount of modification. The only modification necessary would be lifting 50 pound crates.

Now turn to page 293 for the next task.

1

This is mostly correct. However, you cannot violate work restrictions imposed by the treating physician until the conflict in medical opinion is resolved.

Return to page 323 for another choice.

2

There is no need for this. The claimant is working on light duty and there are no clear reasons why he shouldn't soon return to regular duty.

Return to page 311 and choose again.

3

Yes, this is the best choice. An injury that usually resolves itself in 6-8 weeks requires serious investigation if it is still not better after 6 months. Since Mr. Johnson is still an employee of the agency, you can resolve the situation faster with a Fitness for Duty exam. You don't need to go to OWCP.

Turn to page 320 for the following task.

4

Correct. The treating physician states that Perry is now able to work on a limited basis.

Turn to page 274 for the next task.

1

Mostly correct. The modifications for duties 2 and 3 are correct.

Reexamine duties 1 and 4 to see if some imposed limitation could be violated.

Return to page 295 for another choice.

2

Partly correct, but there are some further work limitations that are not included in this description.

Review the work restriction evaluation on page 288, then return to page 296 for another choice.

3

Correct. The treating physician can reevaluate the claimant's condition which may have changed since the previous time.

Turn to page 298 and do the next task.

4

Correct. Since Ms. Washington is a Postal Service employee this special rule applies.

Now turn to page 299 for the next task.

From page 297

1

True. However, this does not deal with the "what if" question. The claimant's condition could get worse. What then?

Return to page 297 and make another selection.

From page 296

2

Mostly correct, but there is still some further change required.

Reexamine the work restrictions on page 288. Then return to page 296 for another choice.

From page 295

3

Partly correct. The answer choices for duties 1 and 3 are not the problem. Reexamine your revisions of duties 2 and 4.

Return to page 295 for another choice.

From page 298

4

In most agencies this is correct. However, Ms. Washington is a Postal Service employee and is subject to special rules.

Check the Resource book page 73, then return to page 298 and select another choice.

1

This is possible but may not be necessary.
Return to page 297 for another choice.

2

Mostly correct, but there is still a work limitation that
would be violated.
Return to page 295 for another choice.

3

Correct. All work limitations have been accommodated.
Turn to page 297 for the next task.

4

Correct. OWCP will make the determination after receiving
the documents from the agency.
Go on to page 302 for the next case.

1

Mostly correct. Reexamine the work restrictions on page 288. Then return to page 296 for a different selection.

2

Correct. All changes are required by Ms. Washington's work limitations.

Turn to page 296 and do the next task.

3

No. Once the employee returns to work, compensation ceases and all income is from employment.

Return to page 298 for another choice.

4

This is possible but may not be necessary and is not her best option.

Return to page 292 and select a better answer.

1

The case may result in a termination of compensation.

But in order to qualify for disability retirement the claimant would have to demonstrate total disability and this is not the case.

Return to page 299 for another choice.

2

From page 299

3

There is no such provision. Rehabilitation results in the claimant getting the same pay, but there is no guarantee of an equivalent job.

Return to page 299 for another choice.

4

COMPENSATION PROGRAM SELF AUDIT

To be effective the compensation specialist must develop the technical skills to thoroughly review initial claims, prepare controversion when warranted, and review long-term cases for re-employment or other disposition.

However, to have a successful compensation program in your installation, you must also develop and maintain effective working relations with three specific groups. These are:

1. The managers and supervisors at the installation.
2. The medical practitioners utilized by claimants.
3. The OWCP District Office that services your claims.

For each group there are specific educational and collaborative activities that are important to initiate.

In order to evaluate the strength and weaknesses of the compensation program at your facility, complete the following tasks:

1. Read pages 77 - 87 in the Resource Book on these three relationships
2. Complete the "Compensation Program Self Audit" and score it.
3. When you have completed and scored the self audit, read the Instructions on page 341, then complete the "Action Planning Sheet" on page 342.

COMPENSATION PROGRAM SELF AUDIT

SECTION I

RELATIONS WITH MANAGEMENT

For each of the following items indicate the extent to which these practices are followed in your installation. Place the appropriate number in the blank provided.

All the time..... = 4

Most of the time = 3

Fairly often = 2

Rarely = 1

Never = 0

1. Supervisors report or have the employee report all compensatory injuries to the compensation office within 24 hours of their occurrence. _____
2. Supervisors see that injured employees immediatly complete a CA-1, and themselves correctly complete and submit the CA-1 within 48 hours. _____
3. The level of information reported by the supervisor on the CA-1 and/or an attached statement is adequate. _____
4. Supervisors recognize the claims that can legitimately be controverted. _____
5. Supervisors correctly follow the rules for time-keeping under COP. _____
6. Supervisory training on claims reporting and handling is provided for supervisors. _____

(CONTINUED ON NEXT PAGE)

7. Supervisors are aware of the technical assistance available from the compensation office and utilize this assistance when needed. _____
8. Information on FECA benefits, basis of entitlement and agency compensation program are disseminated to all managers through administrative instructions, memoranda or other official means. _____
9. Executive and management meetings include a report and discussion of the installation's compensation program at least quarterly. _____
10. The compensation office reports to top management at least quarterly on the compensation costs for the installation. _____
11. The installation management supports a light duty program for temporary partially disabled claimants. _____
12. Organizational units are able to provide sufficient light duty assignments for partially disabled claimants. _____
13. Employees on light duty are periodically (every 2-3 weeks) re-evaluated for changes in their work restrictions. _____
14. Light duty assignments automatically terminate at least within 12 months and a decision is made for permanent disposition of the case. _____
15. Management offers modified jobs to permanently and partially disabled claimants. _____

SUBTOTAL _____

SECTION II

RELATIONS WITH DOCTORS

For each of the following items, use the same scoring system you used for Section I, with 4 indicating "all the time" and 0 indicating "never".

16. At least quarterly compensation office staff hold meetings or make other special efforts to educate medical practices in the community for the purpose of improving the usefulness of medical reports. _____
17. Compensation office staff make sure that local physicians who treat our injured employees are aware of our light duty program. _____
18. The compensation office (or the agency medical office) speaks directly with the treating physician to clarify any work limitations questions in a case. _____
19. Medical practices are instructed to send bills to the agency compensation office. _____
20. Medical practices are instructed by the compensation office on what things OWCP needs in order to process bills. _____
21. Doctors are encouraged to call the compensation office to discuss any questions they may have concerning the accommodation of work limitations for an employee. _____
22. The compensation office uses a list of competent and cooperative medical practices and specialists to assist the employee in selecting an appropriate one. _____
23. Initial medical reports are received from doctors within 4 or 5 days. _____
24. The compensation office contacts the treating physician for an initial status report within 24 hours of the initial treatment if the status cannot be learned from the employee. _____

SUBTOTAL _____

SECTION III

RELATIONS WITH OWCP

For the following questions, place a 3 in the blank if the statement is true and a 0 in the blank if it is not so.

- 25. Compensation office staff has visited the OWCP District Office to learn how OWCP processes claims and bills. _____
- 26. The chief compensation officer has personally met and discussed problems with OWCP's Deputy Commissioner. _____
- 27. Your facility has arranged to get a chargeback listing from OWCP at least on an annual basis. _____
- 28. The compensation office has clarified with OWCP the types of controversion cases that will be upheld. _____
- 29. The compensation office has arranged a system with OWCP to update files. _____
- 30. The Deputy Commissioner or his representative has toured your facility and become acquainted with the type of work done, the equipment used and common injuries. (This would not apply for an agency that has desk-type jobs only.) _____
- 31. The compensation staff has an arrangement to routinely discuss problem cases with claims examiners. _____
- 32. The compensation office has developed good enough working relations with the District Office that you are confident that any serious problem will receive due attention. _____

SUBTOTAL _____

SCORING SHEET

To get your overall score follow these steps:

1. Enter the Subtotal of Section I on the
blank on this line _____
2. Enter the scores for the following items
in the blanks provided:
Item 6 _____
Item 11 _____
Total for Section I _____
Total possible score for Section I is 68.
3. Enter the Subtotal of Section II on the
blank on this line _____
4. Add the following scores:
Item 16 _____
Item 21 _____
Total for Section II _____
Total possible score for Section II is 44.
5. Enter the Subtotal of Section III on the
blank on this line _____
6. Add the following scores:
Item 26 _____
Item 28 _____
Item 31 _____
Total for Section III _____
Total possible score for Section III is 44.

If you are significantly below the possible score for any section there may be serious weaknesses to your program. This is especially true if you scored less than 3 on any of the seven weighted items listed above.

ACTION PLANNING SHEET

INSTRUCTIONS

After reviewing what you consider the most serious weaknesses in your program, select at least one action step that would strengthen your organization's program in some important way.

In selecting an action to plan, use the following criteria:

- a. Choose from 1 to 3 actions. Write them out in the space below.
- b. Choose actions that are within your power to do (something you can do yourself).
- c. Choose actions that you think have a high probability of success.
- d. Choose actions of relatively short range (the results will be visible in 30 to 60 days).

Using the Action Planning Sheet on the following page (342), for one of your actions draw up a plan, with specific steps and a time table. There are two additional Action Planning Sheets on pages 343 and 344 if you want to draw up additional plans.

ACTION PLANNING SHEET

Proposed Action:

Rationale:

Plan:

Action Steps:

Target Date:

1.	<hr/>	<hr/>
2.	<hr/>	<hr/>
3.	<hr/>	<hr/>
4.	<hr/>	<hr/>
5.	<hr/>	<hr/>
6.	<hr/>	<hr/>
7.	<hr/>	<hr/>
8.	<hr/>	<hr/>

ACTION PLANNING SHEET

Proposed Action:

Rationale:

Plan:

	<u>Action Steps:</u>	<u>Target Date:</u>
1.	<hr/>	<hr/>
2.	<hr/>	<hr/>
3.	<hr/>	<hr/>
4.	<hr/>	<hr/>
5.	<hr/>	<hr/>
6.	<hr/>	<hr/>
7.	<hr/>	<hr/>
8.	<hr/>	<hr/>

ACTION PLANNING SHEET

Proposed Action:

Rationale:

Plan:

Action Steps:

Target Date:

1.	<hr/>	<hr/>
2.	<hr/>	<hr/>
3.	<hr/>	<hr/>
4.	<hr/>	<hr/>
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